

Title

A STUDY OF HEALTH AND ILLNESS IN THE
EXPERIENCE OF CHURCH OF SCOTLAND MINISTERS
1930 - 1969

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SUMMARY

The following dissertation reports the findings of a three-year research project concerning "health and illness in the experience of Church of Scotland ministers, 1930-1969". It was conducted against a background of growing concern that the health of this clergy group may have deteriorated significantly in a number of respects in recent years. There was, however, little evidence, beyond personal impressions and limited statistical data, and no previous research to justify this concern or to substantiate the 'popular' assumptions which this concern implied. This programme was then instigated with a view to conducting a multilateral investigation into various dimensions of the health experience of this group of clergymen and with the object of providing a spring-board from which more detailed, microscopic studies in this field could subsequently be initiated.

Part I is devoted to an extensive discussion of the frame of reference within which this investigation was conducted. Consideration is given to the background for this inquiry in terms of the importance of health in the minister's life and work and in terms of previous research conducted elsewhere. The basic principles and assumptions involved in the concept of Total Health, which is intrinsic to the conceptual orientation of this inquiry, and the evaluative criteria which arise out of this concept are established. The case is argued for the adoption of an holistic and multidimensional conceptualization of health, which pays due regard to the multidimensional unity and ambiguity of life in the experience of the whole person within a particular 'world'. Following from this conceptual foundation, the case is argued for the application of a multilateral, eclectic methodology, broadly based on the principles of Existential Analysis and designed to investigate health from different perspectives.

The following segments of the dissertation, Parts II, III, and IV present the findings of the three-phase research programme carried out between October 1967 and August 1969. Part II attempts a description and analysis of the salient structures and characteristics of the Church of Scotland minister's 'world' and 'life-style', especially as these conditions could bear on the individual's health. This initial phase of the programme provides no information about ministers' health per se, but does serve to distinguish these particular clergymen

as an occupational and denominational group and also establishes the context within which all their experiences of health and illness need to be considered. Part III reports the findings of a detailed statistical study of mortality and morbidity in the experience of Church of Scotland ministers. This segment of the dissertation is concerned with the effects and end-results of being a Church of Scotland minister as these are manifested in death and disablement. Statistical data of this kind provides a foundation of empirical evidence from which to make an evaluation of the health of this clergy group and includes valuable comparative data. Attention is then directed, in Part V, to an examination of the personal health experience of Church of Scotland parish ministers. This examination is conducted on the basis of a survey of a representative sample of parish ministers, with the object of investigating the physical, intrapersonal, interpersonal, and vocational dimensions of the individual minister's health experiences. /IV

The principal conclusions which may be drawn from the evidence elicited by this three-phase research programme are then surveyed in Part V. There is good reason to conclude, in the first instance, that Church of Scotland ministers generally enjoy an unusually favourable standard of health by comparison with members of other professions (teachers excepted) and with the Scottish male population. This applies particularly to the physical dimension of their health; but it is also true that no conclusive evidence has come forward to suggest that these ministers are unusually vulnerable to mental, psychoneurotic, or personality disorders and difficulties. In general, the reputation of Church of Scotland ministers for sound health is fully justified by the available evidence: as a group, they enjoy notable longevity, a low rate of death (especially up to the age of 45 years), low rates of death from most major causes of death (especially from diseases of the respiratory system) in the general population, and few deaths or incapacitating disabilities from diseases and disorders directly attributable to neglect, detrimental personal habits, unsatisfactory standards of hygiene, or unfavourable working and living conditions. It seems reasonable to conclude that their faith-commitment, strong sense of personal responsibility and stewardship, observance of positive personal habits, and the external conditions of their life and work have an integrative effect and contribute to the positive health record of these ministers. The only respect, and it is quite outstanding, in

which the health experience of these ministers is significantly unfavourable is the excessive incidence of coronary heart disease as the major cause of mortality and morbidity among them. There is no immediate explanation for this phenomenon.

Against this favourable background, there is some evidence to suggest, secondly, that there has been a decline in the health of Church of Scotland ministers: a decline which can be traced back to the mid-1950s, but which has become more prominent since 1960. This deterioration has been most apparent in the 55-64 age group, with an increasing rate of death, proportionately more deaths and cases of disablement from coronary heart disease, a higher proportion of disablement in younger age groups from psychiatric disorders, and a lower average age of death overall. However, it is emphasized that the magnitude and significance of these developments should not be overstated. The decline has not been dramatic or on a large-scale and it remains true, in comparative terms, that Church of Scotland ministers constitute a relatively healthy group.

Then, thirdly, it is concluded that the main sources of disruption and disintegration in the experience of Church of Scotland ministers are associated with intrapersonal, interpersonal, and vocational factors and processes, and are closely associated with the emotional stresses and intrapersonal conflicts to which they are frequently subject. The cumulative effect of these stresses and conflicts becomes manifest in the psychoneurotic, personality, and psychosomatic symptoms and disorders experienced by these ministers. Particular attention is given to the disintegrative effects of conflicts which these men commonly experience in relation to the relative demands of ultimate commitment and proximate responsibilities ("existential-ontological tension") and in relation to their oscillations between the polarities of freedom and responsibility, holiness and humanity, and isolation and intimacy. Consideration is also given to the theoretical possibility that the integrative and disintegrative experiences of Church of Scotland ministers may be closely related to a common "guilt-neurosis syndrome", in which personality factors and intrapersonal processes are predominant but which also involves interpersonal, social, occupational, and vocational factors in a dynamic and intricate process of interaction.

Then, finally, the dissertation concludes with a speculative theological postscript, setting the health of Church of Scotland ministers within a much wider existential-ontological perspective and tentatively exploring the theme of a basic conflict between processes of self-destruction and self-acceptance.

PREFACE

The research project reported in these pages had its real beginnings, although the author was not consciously aware of it, some four or five years ago when the author held the position of Deputy Director in the Cairnmillar Institute, Melbourne, Australia (The Cairnmillar Institute is a clinical, educational, and human relations institute under the auspices of the Presbyterian Church in Victoria). During this period, the author had cause to be involved in both therapeutic and educational relationships with a number of ministers and their wives. These men came from various denominational backgrounds: predominantly Presbyterian, Methodist, Church of Christ, and Baptist, but also a small number with Catholic and Church of England affiliations. Although it was never systematically formulated or analysed, it began to emerge that these men were subject to peculiar problems and threats to their total health. They seemed to experience several difficulties which they held in common, which aroused the author's interest in the particular health problems of clergymen and, to a lesser extent, of their wives. So the seed was sown: the idea that the health of clergymen would be a valuable area of future inquiry developed as a vague possibility. However, the burden of clinical, educational, and administrative responsibilities never allowed the idea to take definite shape. During this formative period, the author valued and benefitted from the friendship and guidance of Dr. F.A. Macnab, founder and Director of the Cairnmillar Institute.

This seed of an idea may well have lain dormant and would never have germinated or come to fruition but for the active interest and support of members of the Department of Practical Theology in the Faculty of Divinity, University of Edinburgh. On arrival in Edinburgh, when the author was contemplating moving into an entirely different area of academic inquiry, those responsible for his guidance, notably Professor J.C. Blackie and Dr. A.C. Campbell, expressed particular interest in the health of Scottish clergymen as a subject which had received no systematic or detailed consideration. Their interest coincided with expressions of growing concern for the health of ministers in the Church of Scotland, a matter of importance to those responsible for the selection, education, supervision, and care of ministers in this Church. Hence, the author's interest was re-aroused, the seed germinated, research possibilities began to take shape, and the programme reported here was initiated. This decision has never been cause for regret in the ensuing three years.

The author is acutely aware of his indebtedness to many people but for whom this research project, which certainly proved demanding, would never have come to completion. The author wishes to express his gratitude,

to his supervisors, Professor J.C. Blackie (Professor of Christian Ethics)* and Mr. D. McMahon (Director of Applied Psychology Unit), for their singular and combined perspicacity and sagacity, for their incisive questions and positive guidance, and for their support and encouragement;

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and, above all else, to his wife, Wendy, but for whose buoyant and resilient personality, warmth, patience, and astonishing courage and fortitude not even the first steps of 'launching out into the deep' would have been attempted.

Finally, I declare that the following thesis has been composed entirely by myself and that the research involved is my own work, and I accept sole responsibility for all opinions and conclusions expressed within the body of the thesis..

HUGH A. EADIE
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A STUDY OF HEALTH AND ILLNESS IN THE EXPERIENCE OF
CHURCH OF SCOTLAND MINISTERS, 1930 - 1969

GENERAL INTRODUCTION

"It is important that the minister have a reasonable degree of freedom from illness so that he can minister to the needs of others. A primary part of the professional training for the minister is to resolve inner conflicts and achieve freedom from compulsions arising in the unconscious. Regeneration would seem to be a prime requisite of true ordination".⁽¹⁾

D. Blain (1953)

This statement, made by a medical practitioner, expresses one of the major considerations which led to the instigation of the research reported here. The assumption is that it is only possible to minister to the needs of others out of a reasonable degree of health and that illness reduces a minister's ability to exercise his ministry. If this view has any validity and relative health is a fundamental prerequisite for ministry, then it has far-reaching implications for the selection, training, and pastoral care of ministers.

The aim of the research programme reported in these pages, was to study health and illness in the experience of a particular group of ministers, those of the Church of Scotland, between 1930 and 1969. The objective was to investigate and identify processes of health and illness in the physical, intrapersonal, interpersonal, and spiritual dimensions of ministers' lives. It was hoped that it would be possible to uncover and describe processes contributing to wholeness and fragmentation in the personal experience of Church of Scotland parish

(1) Blain, D., "Fostering the mental health of ministers", Pastoral Psychology, 1958,9 (84), p. 9. This article was first published in P.B. Maves (ed.), The Church and Mental Health (N.Y. 1953), p. 254 ff.

ministers in the period under study. For this purpose a three phase research programme was designed which would elicit appropriate evidence and which would provide progressively greater insight into the dynamics of integration and disintegration in the personal experience of these clergymen. This research programme was conducted between October 1967 and August 1969, and the findings are reported in these pages.

At the inception of the study it was believed that such research was necessary and could provide a valuable aid to those responsible for the selection, training, and pastoral care of ministers within the Church of Scotland.

AIM

The aim of the study reported here was to conduct an initial investigation into health and illness in the experience of Church of Scotland ministers between 1930 and 1969. The objective was to undertake a detailed, exploratory study of the total health of these ministers by investigating the physical, intrapersonal, interpersonal, and spiritual dimensions of their experience in terms of processes of integration and disintegration. In undertaking the project there were three expectations. It was expected that it would be possible to identify and describe the processes of integration and disintegration in each of these dimensions, that it would be possible to uncover those processes which manifest health or illness. Then it was expected that any changes in these processes could be determined and that factors contributing to either wholeness or fragmentation could be identified. It was further expected that the ways in which occupational factors and experiences contribute to these processes could be discovered.

This introduction to the general purpose of the study suggests a potentially limitless and uncontrollable investigation, which would

be so diffuse that it would have little value as research. However, it was recognised that boundaries would have to be established which would confine the field of study to manageable and relevant proportions. Although there may be a sense in which literally every experience contributes to health and illness, it was clearly not desirable to undertake such a wide-ranging investigation in order to fulfil the fundamental objectives of this study. Some discrimination and selectivity had to be exercised to establish those areas of experience which were appropriate.

FRAME OF REFERENCE

The field of study was inevitably restricted by determining the frame of reference within which the project was to be conducted. Consideration of the frame of reference also clarified the essential foci to which the research programme was to be directed. Before proceeding it was necessary to consider three preliminary questions from which the frame of reference was derived. These preliminary considerations comprise the substance of PART I.

HISTORICAL BACKGROUND

It was necessary, first, to establish the historical background to a study of the health of Church of Scotland ministers and to determine the extent of existing knowledge and evidence with respect to this (Part I: Chapter 2). It soon became apparent that very little was known, in terms of empirical fact, and that this was a completely new field of study. But from fragments of statistical information available, from research conducted elsewhere, and from generalised opinions based on hearsay and isolated personal experiences, four assumptions or propositions emerged:

That, until recent years, Church of Scotland ministers have had

an unusually favourable health experience by comparison with other occupational groups;

that, the health of Church of Scotland ministers has declined significantly within the last decade;

that, this decline is manifested in every level of their experience: physical, intrapersonal, interpersonal, and spiritual;

that, this decline has been caused by an increase in the particular forms of stress, especially mental and emotional stress, to which ministers are subject in their profession.

These propositions are not sufficiently precise to be expressed in the form of hypotheses which can be tested by experimental methods. But they do provide necessary focal points for an inquiry or fact-finding investigation of the kind attempted here, and they also serve to confine the field of study.

THE CONCEPT OF TOTAL HEALTH

Then it was necessary to determine the nature of health and illness and to establish valid criteria by which they might be identified and assessed. A concept of Total Health (Part I: Chapter 3) is basic to the conceptual framework of this study. This concept is derived from an holistic perspective: that is, one which recognises the fundamental priority and unity of the whole person. In this view, health and illness are not quantities or qualities which a person possesses. They are expressions of the person's entire existence as a human being and are manifest in processes of integration or disintegration in any dimension of the person's existence. Health is characterised by those processes which contribute to wholeness; illness by those which contribute to fragmentation. This orientation requires a research procedure which does justice to

the fundamental unity of the person and which accounts for every dimension of the person's being.

The fundamental unity of the person notwithstanding, some conceptualisation was necessary for research purposes. It is also implicit in the conceptual framework of this study that health and illness, or integration and disintegration, may be experienced in any dimension of the person's being. Therefore, this study aimed to identify and investigate these processes in the physical, intrapersonal, interpersonal, and spiritual dimensions of ministers' experience.

The study aimed to investigate the physical or somatic dimension of ministers' experience in terms of health and illness. One focal point would be their experience of harmonious or disruptive physical functioning. It was aimed to accumulate appropriate empirical evidence, especially in the form of mortality and morbidity data, of this dimension of their experience. It was also designed to investigate the personal standards and habits which could affect the physical well-being of ministers.

The second focal point was to be the intrapersonal or psychic dimension of their experience, with a view to identifying and investigating health and illness in the mental, emotional, and personal realms of their experience. It is assumed that self-realization, individuation, and identity are constitutive for health. So the study was designed to investigate ministers' sense of personal identity and to uncover the sources of anxiety, stress, satisfaction, and frustration in their experience. (1)

- (1) It is important to note, with respect to medical and psychiatric aspects of health and illness, that this study was not intended to be either a medical or a psychiatric investigation. The author does not have the necessary training or qualifications to undertake such an inquiry, and this is frankly acknowledged. The author's background training and experience lies in the field

As a third focal point the study took the interpersonal or societal dimensions of experience. It is assumed that an ability to establish and participate in satisfying and mature personal relationships is also characteristic of health. Obversely, it is assumed that self-absorption is a manifestation of illness. Therefore, the aim was to explore the personal, social, and professional relationships of ministers with a view to identifying manifestations of health and illness in this dimension of their experience.

Then, the fourth focal point for the study was the spiritual or transcendental dimension of experience. In this view of total health it is assumed that a sense of meaning and purpose which takes a person beyond himself and which relates his existence to values beyond himself is characteristic of health and is basic to wholeness, in any essential sense. This could be described as the transcendental dimension or spiritual foundation of existence. Such a sense of meaning may provide a central thrust and source of integration for the other dimensions of a person's being. Hence, the study aimed to investigate the transcendental dimension of ministers' experience and was particularly concerned with their sense of meaning and purpose.

of pastoral theology and pastoral counselling, and it is within these disciplines that the study is conducted. At the CAIRNMILLAR INSTITUTE, MELBOURNE, AUSTRALIA, the author was involved in training clergymen in the discipline of pastoral psychology and counselling and also in therapeutic counselling involving both ministers and their wives.

However, some of the evidence collected has a medical and/or psychiatric orientation. Where this is so the evidence will be presented in a descriptive form and only the most elementary interpretation offered. No attempt to invade these specialised fields is intended. But it is hoped that this initial study and the evidence presented may provide a valuable base-line from which those with specialised qualifications may conduct detailed investigations into these dimensions.

It is quite evident that these "dimensions" are only convenient conceptual constructs which are employed in the interests of clarity and precision. In reality they cannot be separated from one another and cannot be detached from the total experience of the person. They can only be understood as components of the one process, that is, the process of human life as it is experienced by the whole person. In the context of personal experience they clearly overlap at many points and may impinge on one another in an intricate and complex manner. But, in the interests of research, some conceptualisation was necessary. Moreover, this conceptual framework imposed further limits on the area of study. The study was to focus on each of these "dimensions" of ministers' experience and aimed to identify the processes characteristic of health and illness in each and aimed to uncover ways in which occupational factors and experiences affect these dimensions and the processes involved.

METHODOLOGY. Having established the field of study and having clarified the criteria to be employed in evaluating the health of Church of Scotland ministers, the third preliminary task was to adopt a methodology appropriate to the investigation (Part I: Chapter 4). It was necessary to construct a research design which would meet a number of requirements if it was to be both appropriate and effective. A method was required which would do justice to the fundamental unity of the person and it would therefore be holistic and emphasise detailed historicity. The study was orientated toward experience and aimed to uncover both objective and subjective processes in experiences related to health and illness. Therefore, a method was required which would facilitate detailed and systematic investigation of experience, as distinct from behaviour, and which would transcend the traditional

objective-subjective dichotomy. The method would enable the investigation of the objective facts of a person's experience and behaviour which would necessitate careful, detailed and unbiased observation. But the method would also provide insight into the subjective states, moods, and processes associated with these experiences. Basically, a method was required which would achieve a reasonable balance between subjective and objective processes.

It will be evident from the introduction to the conceptual framework of this study that the theoretical orientation of the methodology is to be found in the field of Existential Analysis. The case is argued for the adoption of Existential Analysis as an appropriate method of research in a study of the kind proposed here (Part I: Chapter 4). Such an approach is peculiarly appropriate to a study in which the subject is life-processes and the dynamic, ever-changing phenomena involved in them. It is argued that traditional scientific methods are not only inadequate and inappropriate to such a study but that they may lead to distortion.

The end result of these and other preliminary considerations was the adoption of a Three phase programme in which the investigator would fulfil the role of "participant observer" (Cf. H.S. Sullivan).⁽¹⁾ The study would be in the form of a diagnostic inquiry, a fact-finding investigation, rather than employing a traditional experimental design.⁽²⁾

(1) H.S. Sullivan, The Psychiatric Interview (Tavistock U.K. 1955), p. 19-25.

(2) Initially, serious consideration was given to the possibility of constructing an experimental design which would test the effect of selected occupational variables on the health of ministers of the Church of Scotland and which would compare their experience with that of clergymen of other denominations and with other professional groups. However, this proposal was abandoned in favour of a more comprehensive study for two main reasons. The first was the almost total absence of background information, which made it extremely difficult either to construct meaningful hypotheses or to make an intelligent

Each phase would examine health and illness in the experience of Church of Scotland ministers from a particular perspective, and it was hoped that these phases would be both complementary and supplementary to one another. It was expected that each phase would yield particular facts and insights with respect to the health of Church of Scotland ministers and that each phase would serve to clarify problems raised by the others. This structure was designed to form a total entity and it was expected to afford a comprehensive picture of health and illness in the experience of these clergymen.

PHASE I was designed to be a descriptive study of the minister's life and work (Part II) and aimed to establish the proper context for a detailed study of their health. The aim was to establish those conditions, regulations, expectations and functions which distinguish a minister from a physician or ship-yard worker. What are the characteristic and salient features of the life-pattern which ministers of the Church of Scotland share in common and which distinguish them as an occupational group? Without establishing this context it would have been possible to misinterpret phenomena and experiences associated with their health. This study was not expected to be exhaustive, but it was expected that the salient features of their life-pattern could be identified and described.

selection of variables. To construct an experimental design under such circumstances would have been stabbing in the dark. The second reason for adopting a broadly-based design was a question of priority. In view of the absence of research in this field, it was considered that the top priority was a comprehensive, initial study of this kind which would provide a base-line from which more detailed and specialised research could be conducted in the future. It was realised that this choice would inevitably reduce the degree of precision and would restrict the conclusions which could be drawn from this project.

PHASE II was then directed to the specific facts associated with mortality and morbidity in the experience of Church of Scotland ministers (Part III). It was concerned with their life expectation, death rate, causes of death, rate and causes of morbidity and disablement. In a sense, this aspect of the inquiry was concerned with the end results of being a minister in terms of mortality and morbidity. This would establish statistical facts with respect to their experience as an occupational group and would make possible some comparison between their experience and that of other occupations.

PHASE III would then comprise a personal survey of individual parish ministers with a view to investigating their personal experience of health and illness (Part IV). This survey would be designed to investigate phenomena and problems which emerged from the preceding phases by interviewing a representative sample of active parish ministers. It was expected that such a survey would provide information which would be complementary to the preceding phases and would fill gaps in the over-all pattern of experiences related to health and that it would illuminate the processes involved. The survey would be bound to the preceding phases by two basic questions. On one hand, what is the effect of being a minister on the individual's personal experience? On the other, what are the processes involved in the personal experience of ministers which eventually express themselves in terms of mortality and morbidity?

This structure is not unlike a diagnostic interview in form and intent (Part I: Chapter 4). The purpose was to adopt a design which would probe progressively deeper into health and illness experiences of Church of Scotland ministers in order to identify the manifestations of such experiences, and in order to gain insight into the processes involved in them.

Methodological considerations imposed two further restrictions on the scope of the study. The study would be concerned principally with the experience of parish ministers between 1930 and 1969.

It was decided to concentrate on parish ministers as such because the parish ministry is regarded as the primary form of ministry within the Church of Scotland and engages at least three quarters of the Church's ministerial manpower. The non-parochial ministries⁽¹⁾ involve relatively small groups of men and each has distinctive conditions and characteristics. Therefore, it was decided to exclude the non-parochial ministers for the purposes of this study⁽²⁾ and to concentrate on parish ministers. It was also decided to limit the period under study to 1930-1969. One reason for this was that a union took place between the Church of Scotland and the United Free Church of Scotland in 1929 and there are appreciable difficulties in acquiring data with respect to both groups prior to that date. Also, by confining the study to that period, it is possible to study a clearly identifiable, homogeneous group.

This general introduction is intended only to give a broad impression of the purposes, method, and frame of reference of the

- (1) For example: Overseas Missionaries, Colonial and Continental Charges, Chaplains to the Forces, Administrative and Academic positions, Special Chaplaincies to Universities, Hospitals, Industry, Deaf and Dumb, and Educational Institutions.
- (2) Studies comparing the health of parish ministers with those in non-parochial ministries, with clergy of other denominations, and with other professions would be invaluable. However, it was necessary to limit the scope of this study. To have attempted such comparisons would have expanded the study to unwieldy and unmanageable proportions. Therefore, only minimal comparisons have been made where relevant data was available, as in the investigation of mortality and morbidity. Possibly this is an area to which future research could be directed.

research programme reported here. The frame of reference is discussed and established in Part I; the findings of the three phases of the project are reported in Parts II, III and IV: and the conclusions and main implications arising from the findings are discussed in Part V.

Finally, in introducing the study, there were four main reasons for the instigation of this research programme. It was inspired, in the first instance, by the growing concern for the health of ministers which has become evident in the Church of Scotland in recent years. It appears that the health of ministers has long been assumed within the Church of Scotland and there has apparently been little cause for concern. But recent signs seem to indicate that this assumption may no longer be justified. However, prior to the instigation of this project, no systematic attempt had been made to clarify this doubt one way or the other.

Allied to this growing concern, is the paucity of research in this field, especially in Scotland. An assiduous search by the author unearthed no previous research into any aspect of the health of Scottish ministers.⁽¹⁾ A thorough search found no medical, psychiatric, or psychological studies on this subject. The only evidence which had been collected was contained in the decennial supplements to the reports of the Registrar General for Scotland on occupational mortality and in the Actuarial Reports to the Aged and Infirm Ministers' Fund Committee of the Church of Scotland.⁽²⁾ Beyond these no evidence had been accumulated and no research conducted. So this project was initiated

(1) See Part I: Chapter 2. "Historical and Research Background".

(2) The data from these sources is presented and examined in Part III: The Ministry and Health - Statistical Data.

in the hope that it would open up a new and important field of research and in the hope that it would provide a foundation from which detailed and specialised research could be conducted.⁽¹⁾

Thirdly, this study was motivated by the assumption that a reasonable degree of health is a fundamental prerequisite for ministry and that a minister cannot minister to the needs of others unless he enjoys a reasonable degree of freedom from illness (Part 2: Chapter 1. Health and the Ministry). Simply from a pragmatic viewpoint the minister's health is of obvious importance if the Church is to have an effective ministry. Within the last two decades, however, two other factors in the relationship between the ministry and health have gained greater recognition. The first is that the conditions of the ministry as an occupation may have important effects on the individual's health and that there are probably peculiar health hazards inherent in the ministry as a profession. It is, therefore, important to identify the specific hazards to which ministers are subject and to identify the resources available which could enhance ministers' health. Not only may the ministry affect health, it is also being increasingly recognised that health and illness may affect the individual's ministry in subtle ways. It is in the nature of his occupation that the minister works in close relation to people and it has been recognised that intra-personal and interpersonal manifestations of illness may have profound

- (1) The author's attention was initially drawn to this subject by his experiences in training and counselling ministers of various denominations in Victoria, Australia. In that situation there is, similarly, growing concern with respect to the health of ministers and there is also a complete lack of research to date. For the purposes of research ministers of the Church of Scotland were chosen because they share a common theological background and a common system of government with ministers of the Presbyterian Church of Australia and they comprise a comparatively large group in a relatively compact geographical area.

implications for pastor-parishioner relationships. If the minister's personal needs for satisfaction and security are not met in his private life it has been argued, then it is possible that his professional relationships may be distorted and manipulated in order to satisfy personal needs, so that he is no longer exercising the ministry per se. Therefore, the study was initiated in order to identify the destructive health hazards to which Church of Scotland ministers are exposed and to investigate the ways in which illness may interfere with their ministry.

Lastly, it was hoped that the findings of such a project would provide a useful aid to those who are responsible for the selection, training, and pastoral care of ministers. Moreover, it was hoped that it would make some contribution in helping individual ministers to gain insight into the special problems and pressures to which they are exposed.

PART I

FRAME OF REFERENCE

- CHAPTER 1. HEALTH AND THE MINISTRY.
- CHAPTER 2. HISTORICAL AND RESEARCH BACKGROUND.
- CHAPTER 3. THE CONCEPT OF TOTAL HEALTH.
- CHAPTER 4. METHODOLOGY: EXISTENTIAL ANALYSIS.

CHAPTER I

HEALTH AND THE MINISTRY

"One can only minister to illness out of a reasonable degree of health. Therefore, the minister will avail himself of all the therapies available to him and will attempt to live and work in the realities described by the principles of mental health."

D. Blain (1953)⁽¹⁾

A reasonable degree of health is a fundamental prerequisite for the ministry and illness reduces the minister's ability to fulfil his vocation. This is the basic argument of Dr. Blain's essay on the minister's mental health in which he discusses some of the common health hazards to which ministers are exposed. In view of the importance of the minister's personal health, he also argues, "A primary part of the professional training for the minister is to resolve inner conflicts and achieve freedom from compulsions arising in the unconscious."⁽²⁾ The clear implication is that the efficacy, and possibly the credibility, of an individual's ministry depends to some extent on his experience of health and illness. This is a provocative proposition. But if it has any validity then the health of clergymen is of much more than marginal importance or of purely personal interest to the individual minister.

The importance of the minister's health has gained greater recognition in the post-war era, especially within the discipline of Pastoral Care. This is evident in a growing body of research, focussing attention on the personality, attitudes, emotions, and

(1) D. Blain, op.cit., p. 18.

(2) Ibid., p. 9.

over-all physical and mental well-being of clergymen. A compendium compiled by R.J. Menges and J.E. Dittes (1965), entitled Psychological Studies of Clergymen⁽¹⁾, clearly demonstrates this development.

Approximately 700 entries are contained in this valuable aid to the researcher, with a classification and synopses of all available research projects and discussions in this field. A notable feature is that more than 75% of these had been conducted in the preceding decade, 1956 to 1965. In spite of the increase in the volume of research, Menges and Dittes draw attention to the lack of collaboration and co-ordination between research workers and their stated aim is "to provide an identity for a field of research which has flourished for over a decade" often unknown to those engaged in it.⁽²⁾ They observe that the results of research have been dispersed because of the "multiplicity of influences fostering research"⁽³⁾ and conclude that

"The general level of research reflected in this volume can be described, at best, as preliminary. Scouting parties have ventured out on almost all fronts and have reported. But the difficulty has been the lack of any main body to report to, to consolidate the reports, to plan the strategy of major campaigns".⁽⁴⁾

Nevertheless, the growing body of research, the widespread distribution of such research, and the fact that it has been fostered within several disciplines is indicative of the extent to which clergymen and many aspects of their experience have become the subject of study in recent years.

(1) R.J. Menges and J.E. Dittes, Psychological Studies of Clergymen (Nelsons, N.Y., 1965).

(2) Ibid., p. 11.

(3) Ibid., p. 14.

(4) Ibid.

The projects reported by Menges and Dittes are not all directly related to the health of clergymen. In fact, comparatively few of these "Scouting parties" have ventured into this particular field of inquiry and most of those which have done so have been concerned with various aspects of the mental and emotional health of clergymen. Only three studies (Fecher, 1960, 1964; Meiburg and Young, 1958) are explicitly devoted to their physical health.⁽¹⁾ However, twenty six studies devoted to their mental health are reported and a further thirty-one make indirect reference to this subject.⁽²⁾ This means that, up to the time of this publication, at least sixty investigations had been conducted into various aspects of the health of clergymen. These represent a small proportion of all those reported by Menges and Dittes but, nevertheless, indicate the growth of interest in this area of research.⁽³⁾

The health of clergymen has become the target of closer scrutiny and the subject of more systematic research in the last two decades, and it seems that this interest has been prompted by two main influences. In the first place, there has been widespread concern that the health of clergymen as a group has declined steadily and to

- (1) This should not be regarded as an exhaustive list. Menges and Dittes' aim was to collect psychological studies as such, and medical studies were outwith this purpose.
- (2) Menges and Dittes list the 26 Studies devoted to mental health and illness in Section F: Mental Health and Illness; most of the other 31 studies with an indirect reference to this subject may be found in Section D: Consequences.
- (3) The subjects of some of these studies are nuns or ministers' wives and some of the reported discussions are theoretical and speculative in nature. When these are excluded we are left with 36 studies which report the empirical findings of investigations into various aspects of the health of clergymen. Although this is a small group, it is striking that all but ten of these (i.e. 72%) have been conducted since 1950.

an appreciable extent. It is not clear whether these fears have any foundation but this possibility has provoked research. A second influence behind the growth of research has been an increasing appreciation of the importance of the ministers' health and of the effects which physical or mental illness, emotional disturbances or personality difficulties may have on his ministry.

THREATS TO THE MINISTER'S HEALTH

The health of clergymen came into prominence, as a subject of some concern, in the mid 1950s. At that time widespread publicity was given to claims that the health of clergymen was deteriorating to a marked extent. Behind this conviction lay a belief that clergymen were being exposed to new and more intense threats to their health than had been true in the past. Whatever the truth of these claims, the health of clergymen became a matter of practical concern for Church administrators as well as being a matter of personal concern for individual ministers.

In an article entitled, "Why ministers are breaking down", for instance, W. Shrader (1956)⁽¹⁾ asserted that more clergymen were "breaking down" in the U.S.A. than had been true prior to the war. Basing his argument on general observation and experience, the author attributed this development to over-work and to increasing demands being made on clergymen. He stated that unreasonable expectations were being imposed on ministers and that many of them felt an acute sense of failure in face of unreasonable demands. The argument was taken a step further in an article published in Harper's magazine on the subject of "Why young ministers are leaving the Church" (J. Moore, 1957).⁽²⁾

(1) W. Shrader, "Why ministers are breaking down," Life, Aug. 20, 1956.

(2) J. Moore, "Why young men are leaving the Church", Harper's Magazine, July, 1957.

Moore supported Shrader's contention that the health of clergymen, as a group, was in jeopardy and suggested that this was evident in the increasing number of "drop-outs" from the ministry. However, he maintained that Shrader's overwork hypothesis provided only a partial and superficial explanation. Instead the basic problem lay in an inner conflict between the role a minister is expected to play and the kind of life he wishes to live as a human being. In his view, such a conflict between professional expectations and personal freedom was a prominent source of tension which caused young men to opt out of the ministry.

These articles, widely circulated through the popular press, received a mixed reception and stimulated various reactions from alarm and concern to scepticism and dispute. It was felt by some that they overstated the case and should be treated with caution, particularly in view of their impressionistic and speculative nature. But the response was almost immediate. The journal of Pastoral Psychology for instance, sponsored several projects to evaluate these claims and subsequently devoted two complete issues to the findings and emergent issues.⁽¹⁾

The fears expressed in these articles were not confined to these two writers or to the United States. Similar articles exploring and describing the personal pressures, difficulties and frustrations to which ministers are subject have frequently appeared in Church magazines and journals since then. Indeed, the stereotype of frustrated, perplexed, depressed and tense clergymen has almost become a journalistic cliché. These epithets have certainly had liberal use in popular discussions about the mental and emotional

(1) Pastoral Psychology, 1958, 9(84); 9(89).

state of present-day clergymen.⁽¹⁾ It would be unjust to suggest that all such inquiries have been purely speculative, but in general little information was put forward to support these claims.

Whatever the merits or demerits of such articles and studies, they did call into question the long-standing assumption that clergymen enjoy unusually favourable health and provoked systematic research.⁽²⁾ The general impression which these and other discussions conveyed was that clergymen were being exposed to increasing pressures, demands, frustrations, and conflicts, and that their health was suffering in consequence. The question is whether this impression has any factual foundation. Over against this view, others have expressed the opinion that the health of clergymen has not deteriorated noticeably. On the basis of clinical observation and experience, D. Blain (1953) was able to say, "In my experience, most ministers have a high degree of mental health. That is, they are able to live happily and productively with other human beings within the limits imposed by bodily equipment".⁽³⁾ Also, in direct response to the claims of Shrader and Moore, S. Southard (1958) undertook a survey of available evidence and came to the conclusion that fewer clergymen were being

- (1) Confusion in the Church about the nature of the ministry and feelings of frustration within the ministry did not suddenly develop in the mid-1950s. H.R. Niebuhr and his co-authors described the ministry as "The Perplexed Profession" in The Purpose of the Church and its Changing Ministry (Harper Brothers N.Y., 1956); p. 48 ff. They show that this confusion began to emerge in the pre-war decade. But the articles by Shrader and Moore had the effect of bringing this issue to the attention of a larger audience through popular media. What had been a domestic problem now became a matter of public knowledge and in a way which suggested a dramatic and sudden development.
- (2) The sources and reasons for this assumption, going back into the 19th century are discussed in the following Chapter 2: Historical Background.
- (3) D. Blain, op.cit., p. 10.

admitted to mental hospitals than would be expected on a population basis.⁽¹⁾ He also concluded that significantly fewer clergymen were being admitted to state hospitals than were physicians and lawyers.⁽²⁾ This view was supported by L. Morgan (1958) who compared the rates of admission to mental hospitals in 1946 and 1956 and found that "the proportion of clergymen suffering from mental illness corresponds to the proportion of the population identified with their faith group."⁽³⁾

Others, like C.W. Stewart,⁽⁴⁾ have maintained that clergymen do experience a high degree of frustration and emotional tension even if this does not result in 'breakdown' and hospitalization. Stewart conducted a survey among members of the Institute of Advanced Pastoral Studies which aimed to discover the principal sources of frustration felt by ministers and concluded: "The average pastor is frustrated. He no longer feels that his understanding of his task coincides with what his parishioners expect of him."⁽⁵⁾

The facts of the situation are not clear-cut or decisive, and evidence has been elicited to support both points of view. If anything, the burden of evidence tends to support the opinion that there has not been a marked decline in any aspect of the health of clergymen. Nevertheless, the possibility that ministers may have

(1) S. Southard, "The mental health of ministers", Pastoral Psychology, 1958, 9 (84), p. 46. He reported that the proportion of clergymen in the population (U.S.A.) was 20: 10,000 while only 7: 10,000 mental patients were clergymen.

(2) Ibid., p. 45.

(3) L. Morgan, "Mental illness among the clergy", Pastoral Psychology, 1958, 9 (84), p. 29.

(4) C.W. Stewart, "What frustrates a minister", Christian Advocate, Jan. 1965, IX, 1.

(5) Ibid., p. 9.

become more vulnerable to illness, disablement and death could not be ignored or neglected. In view of its possible consequences for the Church at large, for the local congregation and community, for those responsible for the selection, training and oversight of ministers, these claims were taken seriously as is evidenced in a growing body of research. Partially motivated by these concerns and with a view to clarifying the confusion surrounding this subject, more intensive research has been conducted in the last two decades than was evident in the past. As a result of systematic observation and research, awareness and understanding of the peculiar health hazards and pressures with which ministers have to cope has been greatly enhanced in that time.

HEALTH IN PASTOR-PARISHIONER RELATIONSHIPS

There has also been growing appreciation of the fact that the minister's health has far-reaching implications in the context of the multifarious pastor-parishioner relationships which are fundamental to his ministry. It is in the nature of his vocation that the minister becomes intimately involved in the lives of people and develops an extensive and complex pattern of relationships. Every facet of his work has a pastoral aspect and draws him into some kind of relationship with others: whether he is preaching, conducting worship, counselling or visiting, teaching, officiating at a marriage, participating in a grief situation, sharing in a community organisation, or even letter-writing, he is involved in interpersonal relationships. Awareness of the fundamental importance of the minister's personal health within these pastor-parishioner relationships has been a second major reason for subjecting the minister himself, his attitudes, motives, emotions, physical and mental health to careful scrutiny.

There are three main ways in which illness may interfere with pastor-parishioner relationships and become a grave hindrance to the effective fulfilment of the individual's ministry. In the first instance it is self-evident that illness, depending on its nature and severity, may be a serious drain on a person's physical and psychic resources so that his ability to function productively is reduced. Purely from a practical point of view, the Church depends upon efficient and adequate ministerial manpower and in order to maintain an effective ministry a reasonable degree of health is a basic necessity. This obvious fact is summed-up by Professor Crew when he states that "health is a prerequisite of achievement".⁽¹⁾ Furthermore, any increase in physical or mental illness in any group could be a serious drain on manpower which, if allowed to go unchecked, could multiply the burden on the survivors so that they become more vulnerable to physical or mental breakdown.

A second possibility is that the suffering clergyman may become so self-absorbed and preoccupied with his own complaints that he is rendered incapable of directing his attention to the needs of others. The efficacy of his ministry depends, to some extent, on the quality of the clergyman's relationships, on how well he gets alongside people and on his sensitivity to their situations and needs. Illness inevitably reduces this capacity and for this reason it is important that the minister should have "a reasonable degree of freedom from illness so that he can minister to others".⁽²⁾

It has been observed that a common feature of illness is that the one who is ill tends to become preoccupied with his own person and

(1) F.A.E. Crew (1958), Health, Its Nature and Conservation (Pergamon Press, 1965), p. xii.

(2) D. Blain, *op.cit.*, p. 9.

that his capacity for forming and maintaining satisfactory relationships is consequently reduced. Not uncommonly the sufferer becomes withdrawn from others, self-absorbed, and estranged from his original concerns in the world around him. It could be said that he is then 'dis-eased'.⁽¹⁾ Clearly this kind of involuntional pre-occupation would be a serious obstacle to effective ministry, or to the conduct of any 'caring profession' for that matter, because "The person who is ill is too preoccupied with his own suffering to be sensitive to the needs of others."⁽²⁾ The degree of self-absorption which accompanies illness is relative, varying from person to person and according to the nature and extent of the illness. But even apparently minor ills may be a source of distraction and nagging irritation if allowed to persist. Perhaps a danger of the ministry is that the clergyman can ignore minor but irritating ills all too easily by simply adjusting his programme without seeking appropriate attention. The danger is that he may go through the motions, fulfilling basic professional duties, while maintaining a detached and insensitive attitude in relation to others. It is therefore essential that a clergyman should be reasonably free of illness and that he should utilize the therapeutic resources available to him.

A third, and potentially more harmful possibility is that the ill or disturbed minister may exploit his status and manipulate his professional relationships, albeit unwittingly, in pursuit of personal satisfaction and security. The ill minister may exploit the opportunities afforded by his office for the gratification of

(1) This phenomenon is discussed as a characteristic of illness by Gotthard Booth in a "physician's view" in P.B. Maves, op.cit., p. 3 ff.

(2) D. Blain, op.cit., p. 9.

personal needs and for the alleviation of his inner conflicts. This is obviously an undesirable and potentially dangerous situation. Such role reversal is all the more serious because of the harmful repercussions it may have for the lives of others and it is all the more insidious because in all likelihood it will be the product of unconscious conflicts and compulsions of which the clergyman is unaware. Many therefore consider that supervised training in self-awareness and self-understanding should be a basic component of the minister's professional preparation. Armed with such self-knowledge, he would then be less likely to project his own needs into his professional relationships and less likely to exploit his position or his parishioners to satisfy his personal needs.⁽¹⁾

There are parallels between pastoral relationships, involving the minister and his parishioners, and therapeutic relationships, involving the doctor and his patients, and our understanding of the intricacies of pastor-parishioner relationships has been greatly enriched by studies of the dynamics of doctor-patient relationships.

It is an established principle of psychotherapy that the therapeutic process depends upon the interpersonal interaction between the doctor and his patient, and is summed up by Frieda Fromm-Reichmann thus:

"When the experience is a psychotherapeutic one, it is the interpersonal exchange between the patient and the psychiatrist as a participant observer which carries the possibility of

- (1) The conviction that a fundamental part of the pastor's professional training should be to provide him with a measure of self-understanding and insight into his own needs and conflicts has become a widely accepted principle of Pastoral Theology and has been expressed by many writers: e.g. R. May, (1939), D. Blain, (1953), W. Oates, (1958), E. Evans, (1961), F. Lake, (1966), F.A. Macnab, (1967), and many others.

therapeutically valid interpersonal investigation and formulation."⁽¹⁾

The therapeutic process, therefore, cannot be understood simply in terms of the patient, his symptomatology, and his interpersonal processes. It is necessary to consider the doctor as a participant in the relationship, in terms of his personality, attitudes, motives, and interpersonal relationships.⁽²⁾ Indeed, some suggest that the doctor's facility for engaging in these mutual inter-relationships is a decisive factor in the healing process, and that the eventual outcome of therapy depends as much upon the doctor's self-esteem and his attitude to the patient as it does upon his technical skills or theoretical assumptions.⁽³⁾ The doctor himself, in particular the way in which he functions in personal relationships, has increasingly become the subject of investigation.

Sigmund Freud was the first to explore the psychotherapeutic relationship in terms of the intricacies and vicissitudes of interpersonal processes and he called attention to the part played by the therapist in these exchanges. He was responsible for recognizing that aspects of the relationship are transferred by the patient: that is, they are carried-over from interpersonal difficulties with significant people in the patient's early life which affect his attitudes and

- (1) F. Fromm-Reichmann (1950), Principles of Intensive Psychotherapy (Phoenix, 1961), p. xiv.
- (2) Ibid., p. xv.
- (3) The idea that the therapist's attitude to the patient may be decisive is expressed by Fromm-Reichmann, *ibid.*, p. xi f. and is also put forward by A. Storr, The Integrity of the Personality (Penguin Books, 1966), p. 20.

responses to the therapist. But he also saw that the doctor's attitudes, emotions, and responses in the therapeutic could be equally influenced by his early interpersonal experiences and conflicts with significant people in his infancy and childhood. These "counter-transference" experiences of the doctor could distort his professional relationships and could disrupt the therapeutic process. His neurotic defences and unresolved problems carried over from the past could be an obstacle to achieving a positive therapeutic result. This possibility was the main reason for Freud's insistence that the therapist should undergo personal psycho-analysis and inspired his maxim that the essential quality for an analyst is "inherent insight into the human soul - first of all into the unconscious layers of his own soul - and practical training".⁽¹⁾

In Freud's teaching, these transference and counter-transference phenomena which the doctor and patient experience with one another are associated with their respective Oedipal constellations and with unresolved problems surrounding relationships with parents. H.S. Sullivan, however, put forward the view that these problems could not be confined exclusively to relationships with one's parents, especially with one's father. He employed the term "parataxis" instead of "transference" and "counter-transference". Parataxic distortions, in his view, are distortions of judgment and perception occurring in a person's present inter-personal relationships which stem from the sum total of the individual's previous interpersonal experiences, especially those of early childhood but not necessarily or exclusively in

(1) S. Freud, The Problem of Lay Analysis (Brentano's, N.Y., 1928), p. 11.

relation to parents.⁽¹⁾ In response to anxiety provoked by early difficulties in personal relationships the individual develops characteristic patterns of interpersonal interaction which are repeated in later life and which colour all subsequent relationships.

Freud and Sullivan, despite marked points of theoretical disagreement, both drew attention to the importance of the doctor's personality, background experience, and characteristic interpersonal processes in the therapeutic process. They clarified the intricate and subtle processes governing the exchange between the doctor and patient and recognized the possibility of the relationship being distorted or disrupted by the doctor's "counter-transference" or "parataxic" experiences.⁽²⁾

In a perceptive and comprehensive discussion, Fromm-Reichmann explores the psychiatrists part in therapeutic processes and emphasizes the importance of satisfaction and security in the doctor's life if he is not to exploit patients for his own ends.⁽³⁾ She suggests three fundamental prerequisites if the psychiatrist is to avoid psychotherapeutic blundering by reacting to patients and their data along the lines of his own anxieties or by manipulating therapeutic

- (1) The concept of parataxic distortion is elaborated in H.S. Sullivan, The Psychiatric Interview (Tavistock, 1955), pp. 25-27, 230-231, and The Interpersonal Theory of Psychiatry (Tavistock, 1955) pp. 28-29, 83-84 et al.
- (2) Fromm-Reichmann, op.cit., pp. ix, 3-6 provides a useful summary of the respective contributions of Freud and Sullivan to the understanding of these phenomena with reference to the therapist's role in the relationship.
- (3) Ibid., pp. 3-42.

relationships in the interests of personal fulfilment.

First, the psychiatrist must have adequate sources of satisfaction and security in his private life. In her own words,

"If it is true that the therapist must avoid reacting to patients' data in terms of his own life-experience, this means that he must have enough sources of satisfaction and security in his non-professional life to forego the temptation of using his patients for the pursuit of his personal satisfaction and security."⁽¹⁾

This is a fundamental principle. The need for satisfaction and security will inevitably play a part in the doctor's life but they should interfere with his ability to listen and with his professional relationships as little as possible. Therefore, their fulfilment in his private life is of crucial importance.

In the second place, the therapist must have "reasonably stable self-respect"⁽²⁾ because his attitudes to himself and to others are complementary. Therefore, Fromm-Reichmann observes,

"the psychiatrist's self-respect is of paramount significance for the therapeutic procedure. If it is true that one's ability to respect others is dependent upon the development of one's own self-respect, then it follows that only a self-respecting psychiatrist is capable of respecting his patients and of meeting them on a basis of mutual equality."⁽³⁾

(1) Fromm-Reichmann, op.cit., p. 7.

(2) Ibid., p. 16.

(3) Ibid., p. 17. This basic principle, founded on the fact that one's attitudes to oneself and to others are complementary, is summed up in an assertion by H.S. Sullivan quoted by Fromm-Reichmann, p. xiii: "One can respect others only to the extent that one respects oneself." C.J. Jung also stressed the importance of self-respect and self-acceptance if the doctor is to respect and accept his patient, as in Modern Man in Search of a Soul. (Kegan Paul, Trench, Trubner, 1934), p. 270 f.

The doctor's self-respect has long been recognized as a basic quality in therapeutic relationships, because his self-esteem or lack of it will affect his attitudes towards others.

Then the third prerequisite is that the therapist should undergo personal analysis designed to acquaint him "with the dynamic significance of his own developmental history", through which he can gain insight into his own interpersonal processes and by which he may gain a measure of freedom from unconscious conflicts and compulsions.⁽¹⁾ The achievement of satisfaction, security and self-respect can only ever be partially realized, and "no amount of inner security and self-respect protects the psychiatrist from being as much a subject of and vulnerable to the inevitable vicissitudes of life as is anyone else."⁽²⁾ It is therefore all the more important that he should gain sufficient awareness of his own problems and needs so that, equipped with self-knowledge, the sources of dissatisfaction and unhappiness in his own life do not interfere with his emotional stability or intrude in the therapeutic process.⁽³⁾

It may seem that this discussion is something of a digression. However, insights into the complex interaction between the doctor and patient derived from psycho-analytic and psychotherapeutic inquiry have broader application. They have implications for all "caring

(1) Fromm-Reichmann, *op.cit.*, p. 42.

(2) *Ibid.*, p. 41.

(3) *Ibid.*, p. 40 f. It is advisable, she suggests, for the doctor to find out what types of patient respond best to his personality and also to recognize those with whom he experiences particular difficulty. He should then be prepared to refer the latter to another therapist.

professions", including the ministry.⁽¹⁾

The relevance of this line of inquiry for the ministry and for all pastor-parishioner relationships has long been recognized. There are many ways in which the minister's 'counter-transference' or 'parataxic' experiences and his needs for satisfaction, security, and self-esteem may interfere with and distort his pastoral relationships. If this is so then his over-all well being is of vital importance.

As early as 1939 Rollo May applied this knowledge to the role of the religious counsellor in pastoral relationships and focussed particular attention on the significance of the counsellor's personality in these interpersonal transactions.⁽²⁾ On the basis of his supervision of many religious counsellors, he suggested that the "typical religious worker" brings certain common personality problems and conflicts into counselling relationships and that these recurring characteristics amount to a "typical neurosis". He identified six common characteristics⁽³⁾: they tend to relax less often than others

- (1) These insights have relevance for the personnel officer, probation officer, nurse, teacher, social worker, welfare officer, general practitioners, and all others engaged in interpersonal relationships of a caring kind. An interesting example of the application of these principles and insights is provided by M. Balint's (1957) investigation into the ever-changing doctor-patient relationships in the context of General Practice: The Doctor, His Patient and the Illness (Pitman, 1967). At the outset he says that the "most frequently used drug in general practice is the doctor himself", but unfortunately text-books provide no guidance as to the "application of this drug" (p. 1). It could be said that the most common agent of the ministry is the clergyman himself. A study comparable to Balint's would be invaluable, but, as far as this author is aware, there has been no thorough investigation into the processes involved in the ever-changing pastor-parishioner relationships.
- (2) R. May (1939) The Art of Counselling (Abingdon Press, N.Y.).
- (3) Ibid., p. 165 ff. Chapter VIII: "The Personality of the Counsellor".

and experience a high level of tension; they have a strong, sometimes excessive, sense of responsibility accompanied by a dread of failure; they are highly ambitious with a strong drive to succeed, sometimes culminating in a sense of indispensability; frequently they have not solved the problem of sexual adjustment and their sexual relationships are marked by suppression, sublimation, and rationalisation; they have great concern for detail and are ridden by a sense of duty which virtually amounts to a "compulsion neurosis"; and they manifest feelings of insecurity and inferiority, often expressed in authoritarian and judgmental attitudes toward others. May emphasizes that any of these neurotic trends, especially if they remain unconscious, may have subtle and far-reaching repercussions in the context of all pastor-parishioner relationships.

The basic point is that the quality of the clergyman's interpersonal relationships may be decisive in fulfilling an effective ministry and it is, therefore, crucial that his personal complaints, unresolved conflicts, experiences of dissatisfaction and insecurity should be minimal if they are not to distort his professional relationships.

The physically, mentally or emotionally disturbed minister's quest for satisfaction, security, admiration, respect, prestige, and self-esteem may have unfortunate consequences for his ministry. An unsatisfied need of intimacy may be alleviated by cultivating the dependence of others or by eliciting expressions of admiration and approval from them. His unfulfilled fancies of seduction may be gratified, in fact or in fantasy, as he identifies with intimate and sexual experiences related to him, as he takes pleasure in the lonely woman's dependence and excessive gratitude for his help, or as he

uses his preaching as a symbolic means of seduction. Any fears of intimacy and horror at the prospect of being dominated or smothered may lead to withdrawal from all forms of close personal contact and he may become detached from and insensitive to the needs of others and retreat into the world of his study and books. An underlying feeling of inferiority and inadequacy, perhaps masking fancies of omnipotence, may be compensated by the authoritarian power he is able to exert over a captive audience from the pulpit, or he may hide his inferiority behind professional pompousness and judgmentalism. As he seeks to gain respect and prestige he may find it difficult to tolerate opposition or challenges to his irrational authority, provoking hostility and bitterness in his relationships. He may attempt to bolster his lack of self-esteem and inner security by unconsciously evoking flattery, admiration, trust, and dependence from others.

There are innumerable ways in which the clergyman's professional conduct may be geared, consciously or unconsciously, to the fulfilment of egocentric needs. The intrusion of egocentric needs into his ministry means that the clergyman is no longer the one who ministers: he has become instead, by means of these subtle devices, the recipient of the care of others. To an extent this is inevitable. As a finite, fallible creature, as much exposed to the hazards of existence as anyone else, the clergyman needs the approval and affection of others and needs a sense of personal worth and achievement. But when the gratification of his own unfulfilled needs becomes the predominant factor in his ministry then the repercussions in his own life and in the lives of others may be disastrous.

Although he may be unaware of the processes by which role reversal has occurred, the fact that he has failed to fulfil his

vocation may register unconsciously to the detriment of his sense of integrity and self-respect. His sense of guilt and self-disgust may be manifested in lethargy, depression and intro-punitive hostility and may eventually disclose itself in peptic ulcers, chronic indigestion, hypertension and other physical symptoms and disorders. The consequence in his own life may be to set in motion a vicious chain-reaction of inertia, guilt, inner rage, self-punishment and physical disintegration.

The impact of his influence on others may be no less destructive. He is in position to promote or retard the development of others and may be instrumental in enhancing or hurting their self-respect and well-being. An off-hand remark, concealing his own insecurity or dissatisfaction, may precipitate an acute sense of guilt in another. An insensitive or sarcastic comment in a letter, manifesting his repressed hostility, may inadvertently arouse the recipient's anxiety. An apparently harmless flirtation, exposing his unsatisfied need of intimacy, may cultivate a dependent relationship with hysterical overtones or may evoke disturbing fantasies in the object of his attentions. Inept mismanagement of a parishioner's dependence or hostility, due to his own anxiety, may provoke a depressive reaction or, at worst, a suicidal episode. The emotional difficulties which may be provoked by the clergyman could be compared with iatrogenic illness, that is any emotional disturbance unwittingly precipitated by the doctor's attitude, examination, or comments to a patient, and is a possibility which no clergyman can afford to ignore in the conduct of his ministry.

Certainly these are extreme hypothetical possibilities and may rarely occur in reality. But the fact remains that such possibilities

exist whenever the clergyman's narcissistic needs colour all his personal relationships and his ministry is then little more than the instrument of his egocentric striving.

If it is true, and it seems beyond dispute, that the clergyman's needs for basic satisfaction and security can distort his perception of the needs of others, disrupt his inter-personal relationships, and damage the development and self-respect of others, if these needs are not adequately fulfilled, then the clergyman's health is a matter of considerable consequence. It is then essential that he should enjoy a reasonable degree of over-all health and that, as far as possible, his physical, emotional and interpersonal needs should be met in his private life. The minister owes it not only to himself but to others to take appropriate steps to protect and promote his personal health. It means, in the second place, that the minister needs to face up to the problems of his own life, his own dissatisfactions and conflicts, his own methods of defence, evasion, and self-deception if he is not to have a distorted perspective of the situations and needs of others and if he is not to exploit them in order to solve his own problems and to meet his own needs. A measure of self-understanding, gained under suitable supervision, is therefore not only desirable but is an essential component of the minister's professional equipment. Then, thirdly, if and when his complaints become a source of distraction and pre-occupation and interfere with his ability to perceive and respond to the needs of others, he will avail himself of whatever sources of treatment are available to him. If these basic requirements are met, it has been argued, then the clergyman is less likely to fall into the trap of

exploiting his parishioners or of manipulating his professional status in his pursuit of personal satisfaction and security.

The dynamics of pastor-parishioner relationships are not our immediate concern in this study. But the health of clergymen does assume special significance when considered in the context of these pastoral relationships. Apart from the obvious fact that illness is debilitating and reduces the individual's capacity to function effectively, it has been argued that illness may strip the individual's ministry of significance. If the minister is dissatisfied and preoccupied with his own complaints he is rendered incapable of recognising or responding to the needs of others and can no longer fulfil his vocation. Furthermore, if a minister's interpersonal relationships are distorted and disrupted by his own conflicts and unsatisfied needs, then a reversal of roles may occur as he uses his status and professional relationships to satisfy purely personal, self-centred goals. In either case he is no longer exercising his ministry as such.

Together with growing concern that the health of clergymen may have been deteriorating, recognition of these possibilities and of their potentially destructive effects for both the minister and those whom he serves has been responsible for prompting the upsurge of more intensive research in the last two decades. It was against this background that this particular study into the health of Church of Scotland ministers from 1930 to 1969 was instigated. Like the growing body of research to which it is related, this study was motivated by concern that the health of this group may have deteriorated in the post-war era and by appreciation of the far-reaching implications of the minister's health.

HEALTH AS A PROXIMATE GOAL

It may be that the preceding discussion appears to attach undue importance to the individual minister's resources, competence, and health. Furthermore, it may seem to imply an impossible ideal of health as a basic requirement for the ministry. In order to keep the minister and his health in perspective some qualifications should be offered.

It must be acknowledged, in the first place, that the efficacy of a man's ministry does not ultimately depend upon his personal influence, attributes and resources. The outcome of his ministry does not stand or fall, in an ultimate sense, on the individual's strengths or weaknesses. Such a notion would be contrary to the Gospel which he communicates and of which he is the agent. He is a mortal creature and subject to the conditions of existence like anyone else and it is important that he should acknowledge and accept his fragility and limitations as a human being. He is not indispensable or indestructible. The danger of placing too great dependence upon his own strength and self-reliance has been expressed by Erastus Evans:

"The pastor who trusts in his personal influence and power is ultimately heading for failure and breakdown. The real work of the pastor only begins when he realises that his personal influence cannot change a human being or meet a really fundamental human need. Indeed, he is not a pastor until he has this sobering knowledge."⁽¹⁾

In other words, as W. Oates has pointed out, the minister's personal health must be kept "subordinate to, and in focus with, the chief end of his existence, namely, "to glorify God and to

(1) Erastus Evans, Pastoral Care in a Changing World (Epworth Press, 1961), p. 14.

enjoy him for ever".⁽¹⁾ Any concern for his health must be considered as a proximate and provisional concern, along with many other such concerns, in the over-all framework of his ultimate concern. If the minister has this over-riding sense of purpose and if he acknowledges the limitations imposed by his humanity, then his health can fit into place as a valid proximate goal and as a necessary means to an end. Given the perspective of his ultimate purpose and given the limitations of his existence, the minister is less likely to acquire an exaggerated sense of his own importance or a false impression of his own indispensability. The point is that a minister needs a sense of purpose and needs to recognize and operate within the limits of the resources available to him.

Moreover, seen in terms of the essential purpose of the ministry, we should not be too hasty in assuming that only the apparently "normal" and "healthy" minister, judged by the generally accepted standards of health, is capable of exercising an effective ministry. In some cases sick or disturbed ministers have not only been effective but have made unusually valuable contributions to the ministry.⁽²⁾ R.D. Laing, in questioning the concepts of sanity and normality, takes this notion to its logical extreme when he argues that "the cracked mind of the schizophrenic may let in light which does not enter the intact minds of many sane people whose minds are closed. Ezekiel, in Jasper's opinion, was a schizophrenic."⁽³⁾

- (1) W.E. Oates (1958 (a)), "The Healthy Minister", Pastoral Psychology 1958, 9, 84, p. 18.
- (2) Cf. *ibid.*, p. 20. He points to George Fox, John Bunyan, H. Wheeler Robinson, H.E. Fosdick, and Anton Boisen as examples of ministers suffering from relatively severe personal difficulties but who were able to make significant contributions to the ministry.
- (3) R.D. Laing (1960), The Divided Self (Pelican Books, 1965), p. 27.

However, although the clergyman's health must be considered in the light of his ultimate purpose, this does not mean that neglect or complacency are then justified. If illness can be a stumbling-block which can thwart the fulfilment of his vocation, then the minister will take steps to minimize this obstacle and the attainment and preservation of a reasonable measure of personal health can be properly regarded as a valid proximate goal for the minister.

It would be unreasonable and unrealistic to suggest or expect, in the second place, that the minister should gain no satisfaction or security from the fulfilment of his vocation. His vocation is a fundamental aspect of who and what he perceives himself to be and permeates his life. This being so, it is inevitable that the effective fulfilment of his vocation, according to his own expectations, should contribute to his self-esteem and sense of personal worth.

This is part of the ambiguity of any "caring profession". In giving to and caring for others the one who gives inevitably receives some satisfaction and at least partial gratification of desires for respect, prestige, achievement, intimacy and affection. To deny the presence of such ambiguous, two-sided motivation in the ministry or any other "caring profession" would be a mistake and to require that the minister should derive no gratification through the effective conduct of his vocation would be unreasonable. Another point of ambiguity, moreover, is that just as the minister may affect the growth of others so too his own development may be similarly enhanced or curtailed or even regressed through the exercise of his ministry. The ambiguity of all personal relationships, whether private or professional, has been highlighted by R.D. Laing:

"We are not self-contained monads producing no effects on each other except our reflections. We are both acted upon,

changed for good or ill, by other men; and we are agents who act upon others to affect them in different ways. Each of us is the other to others. Man is a patient-agent, agent-patient, inter-experiencing and interacting with his fellows."⁽¹⁾

This reciprocal "patient-agent" quality of all relationships is as inescapable in the ministry as in any other area of human life. Just as other people may need him, so too it must be recognised that he needs them and without them he would be deprived of role, status, and an important source of satisfaction.

However, if it is acceded that the minister's personal needs and growth affect and are affected by his vocational and professional relationships, it does not follow that he can therefore afford to be complacent about his health. On the contrary, it is then all the more important that he should be aware of his own needs and of the ways in which he relates to others. Such self-understanding would not necessarily reduce or eliminate his needs, but it would make it possible to ensure that they did not predominate in his ministry and to avoid the danger of facilitating his own growth at the expense of the self-respect and development of others.

As a third qualification, it must be stated that the clergyman has no immunity from the vagaries and exigencies of existence. He is as much involved in the hazards of human existence and as much exposed to the possibilities of physical, neurotic, psychosomatic and psychotic disorders as is anyone else. In the words of Professor M. Millar,

"We see, therefore, that anyone of us may become casualties in the conditions of modern culture. There are today no

(1) R.D. Laing, The Politics of Experience and the Bird of Paradise (Penguin Books, 1967), p. 25 f.

priests of healing set apart from the ruck of suffering mankind, no alchemists with the secret of health and life, no therapeutic oracles to whom we can go for the Vital Answer. We are all in this together. We are all most feeble and fallible. It may be my turn next."⁽¹⁾

The minister, in common with all his fellows, is a potential statistic; and not even the most thorough hygienic precautions, the most rigorous self-analysis, the most stringent training, or even the most secure faith, all put together, will provide him with immunity from his mortality and from the limitations, anxieties and dilemmas intrinsic to his humanity.

On the surface, this may appear to be an obvious and unnecessary statement. However, it may be salutary and sobering for the minister to consider his health in the framework of his creatureliness and finitude. This perspective may serve as a corrective to any feelings of his indispensability and to any belief in his own invulnerability which he may possess, and may serve to reduce any sense of his own power and influence to realistic proportions. Moreover, recognition of his own finitude may enable him to realise that his own needs and difficulties are no different in kind from those of others to whom he ministers. Perhaps personal experience of illness and suffering is necessary if the minister is to empathise with the afflictions of others⁽²⁾ and if he is not to acquire a grandiose sense of his own adequacies.

Furthermore, this perspective may enable the minister to avoid the opposite extreme of excessively critical and morbid self-

(1) M. Millar, "Mental Health and Spiritual Wholeness", Journal of Societal Issues, Vol. 1, No. 1, 1964, p. 9.

(2) Cf. D. Blain, op.cit., p. 9.

appraisal. As Menges and Dittes observe, "the effectiveness or adequacy of performance in response to his call is necessarily subject to excruciatingly personal appraisal."⁽¹⁾ The minister, his life governed by a sense of responsibility to God, may be disposed to interpret his own weaknesses, failures, and even his afflictions as a measure of his fidelity and integrity in fulfilling his religious vocation. Personal inadequacies may be perceived all too easily as failures in exercising his ultimate responsibility, culminating in guilt, remorse, and self-punishment, perhaps manifested in acute anxiety or severe depression. It is crucial that the minister should acknowledge and accept his limitations as a finite creature and that he should recognize, in any event, that the efficacy of his ministry does not ultimately depend upon his personal adequacy. Given this outlook, he may be able to establish realistic goals and to avoid the danger of imposing unattainable and potentially destructive expectations on himself.

Then, lastly, given the perspective of his over-riding purpose in life and of his humanity, the minister is less likely to indulge in the "idolatry of health"⁽²⁾ or to engage in the futile pursuit of health as an absolute end in itself. It may be that health is lost, in fact, to the extent to which it becomes the predominant preoccupation in a person's life and is pursued as an ultimate goal in itself.⁽³⁾ The ambiguous, provisional, and illusory qualities of health and disease in human life are conveyed in the ideas expressed by Rene Dubos:

(1) R.J. Menges and J.E. Dittes, *op.cit.*, p. 12.

(2) W.E. Oates, *op.cit.*, p. 18.

(3) Gotthard Booth in P.B. Maves (ed), *op.cit.*, p. 15.

"Wherever he (man) goes, whatever he undertakes, he will encounter new challenges and new threats to his welfare. Attempts at adaptation will demand efforts, and these efforts will often result in failure, partial or total, temporary or permanent. Disease will remain an inescapable manifestation of his struggle.While it may be comforting to imagine a life free of stresses and strains in a carefree world, this will remain an idle dream."⁽¹⁾

The minister, like his fellows, is involved in this struggle and has no dispensation from the possibilities of failure and disintegration in his life. Therefore, he would not expect his oscillations between the poles of integration and disintegration, fragmentation and wholeness to be any different in kind from the experience of his fellowmen.

These qualifications are very necessary before embarking on a study of clergymen and their experience of health and illness. Their health can only be seen in perspective when considered within the framework of their vocation and within the context of their human existence. There is no way for them to attain absolute health or complete freedom from the polar tension between health and illness, and it is not possible for them to eliminate the relative perils of disease, anxiety and insecurity or to evade the absolute threat of death inherent in their existence. To pursue such a goal is futile and self-defeating. Nevertheless, it still holds true that the clergyman's health is of fundamental importance if he is to exercise an effective ministry and that the attainment of reasonable, over-all health is an appropriate and responsible proximate goal in achieving this end.

(1) Rene Dubos, Mirage of Health (Geo. Allen and Unwin, 1960), p. 221.

THE HEALTHY MINISTER

Relative health, however, is a non-specific goal which requires some clarification. Health is multi-dimensional and can only be properly understood as the composite expression and effect of the complex constellation of factors and processes which comprise the whole person.⁽¹⁾ Many processes, physical, mental, emotional, vocational, interpersonal, and environmental, will bear on the clergymen's health in dynamic and intricate ways.

As a result of recent research into the health problems of clergymen, a number of specific and realistic objectives have been suggested which would serve to enhance their health. The following prescriptions for the promotion of the individual minister's health are those most commonly put forward.⁽²⁾ Some of them are simply matters of commonsense, while others have been stressed by various writers because inquiries have shown them to be blind-spots or sources of difficulty for clergymen.

(i) Sense of meaning and purpose

The minister needs to have a clear sense of purpose and meaning, a focal point beyond himself which gives his life a sense of direction and which serves to integrate each of his provisional concerns and responsibilities. In order to maintain this sense of purpose, he will constantly reevaluate and clarify his objectives and make some

- (1) These comments anticipate the concept of total health which is fundamental to the conceptual orientation of this study and is elaborated in Chapter 3 following.
- (2) As for example by W.E. Oates' discussion of "The Healthy Minister" op.cit., and by D. Blain's article on "Fostering the mental health of ministers" (1953), op.cit. Both establish sensible and realistic guidelines for the health of ministers. Similar ideas are expressed in popular journalistic form by A.D. Dennison Jnr. "Physician to Pastor: Golf Isn't Enough", The Christian, Jan. 24, 1969. •

appraisal of his progress in attaining them.

(ii) Awareness of limitations

A flexible concept of health is necessary if he is to recognise and accept the limitations imposed by his finitude and personal resources and if he is to avoid the pursuit of unattainable goals in his personal life. This perspective is important if he is not to be swamped by feelings of failure and inadequacy and if he is to function productively within his limits.

(iii) Physical satisfaction

He will aim to safeguard his physical well-being by observing suitable habits and hygiene standards. It is essential that he should gain adequate satisfaction for his physical and emotional needs, including nourishment, exercise, sleep and rest, sexual gratification, and the avoidance of physical loneliness. As far as possible, it is desirable that the need for such forms of satisfaction should be met in his non-professional life.

(iv) Individuation and a sense of Identity

A sense of his own uniqueness and worth as an individual is also a basic component of the minister's health. His capacity to relate to others, to work effectively with others, and to be sensitive to the needs of others will depend upon the extent of his self respect and his sense of personal identity and integrity. The process through which such a sense of uniqueness as a separate person is gained has been variously described as individuation, self-realisation, the growth of identity, and self-actualization.

(v) Intimate interpersonal relationships

Secure and intimate relationships are necessary in order to meet his need for intimacy, dependence and interdependence, affection, and

emotional security. The minister needs such satisfying, "ventillating relationships" (Cf. W. Oates, 1958, p. 26) in his private and social life if he is to avoid the danger of exploiting his parishioners in his quest for intimacy. In fact, individuation and intimacy, distinctive separateness and interpersonal unity are complementary poles, and a capacity to fully engage in intimacy is a mark of the individuated person, and vice versa.

(vi) Positive expression of emotion

The minister needs to cultivate his capacity to experience emotion, his capacity to love, fear, dislike and desire, and needs to develop his facility for expressing his feelings positively without surrendering to repression and unnecessary self-suppression. In his position, this aspect of the minister's health may present problems, especially when he experiences feelings associated with sexuality and affection or with hostility and aggression. These emotions may cause him difficulties, but it is important that he should allow himself to be conscious of them and should find appropriate and acceptable means for expressing them.

(vii) Provision for recreation

A flexible and balanced use of his time also contributes to the minister's health. It is important, in planning his time, that he should make adequate provision for recreation, relaxation and renewal. In setting himself tangible and realisable short-term goals, allowance needs to be made for play, marriage and family life, personal interests, social life, and private devotion if the minister's resources are to be preserved and replenished.

(viii) Growth of self-understanding

Under suitable supervision, the minister may develop an awareness

of his own needs, emotions, conflicts and dissatisfactions and may grow in understanding of the factors and dynamic processes in his own background and personality which contrive to influence him. Self-understanding and self-awareness are considered by many to be essential characteristics of the healthy minister. Also, the minister should not hesitate to seek appropriate treatment whenever his complaints become a source of preoccupation and distraction or prove to be unmanageable.

These prescriptions serve to reflect the multidimensional nature of health and direct attention to the need for balanced, multi-lateral growth in every dimension of the person's life: physical, mental, emotional, social, vocational and spiritual. None of these dimensions of the person's experience can be regarded as self-contained entities apart from the other dimensions and apart from the whole person. They impinge on one another in an intricate and dynamic manner. But this is to anticipate what follows in discussing the concept of total health.

The point is that the minister can establish tangible and reasonable goals in order to promote his personal health and needs to strive for balanced, multi-lateral growth as one expression of his responsibility.

SUMMARY

The purpose of this initial discussion has been to establish the general context and broad conceptualities within which this particular study was conducted. The aim of this project, in general terms, was to investigate health and illness in the experience of Church of Scotland clergymen between 1930 and 1969, with a view to opening up

a new field of research in so far as Scotland is concerned. However, it does fall within an extensive body of research and inquiry which has developed and flourished in the post-war era, as is evident in the increasing attention devoted to many facets of clergymen's experience in that time.

It has been suggested that this development may be attributed to the influence of two principal factors. In the first place, the experience of clergymen has become the target of closer investigation in response to the widely expressed fear and concern that clergymen may have been exposed to more intense pressures and that their health as a group may have suffered in consequence. It remains to be seen whether this is true of Church of Scotland clergymen. In the second place, the expansion of this field of research has been motivated by a growing appreciation of the importance of the clergyman as an agent of the ministry and of the potential repercussions which the clergyman's health may have in the conduct of his ministry. Both these factors, allied with the total absence of previous research in this country, prompted the instigation of this inquiry into the health of Church of Scotland clergymen.

In order to keep the minister and his health in perspective, three preliminary qualifications have been offered. First, the minister's health should be considered in the framework of his vocation and central purpose in life. All of his provisional concerns and responsibilities, including his personal health, should be seen as subordinate to and in focus with the over-all purpose of his life and as means to achieving that end. Second, the minister's health can only be understood properly within the context of his human

existence. In the conditions of existence, the person's health will always be relative and ambiguous, never absolute and ideal. Third, the minister's health will be seen as a provisional goal, not as the ultimate purpose of his life, and reasonable attainment of this objective will be contingent upon multidimensional integration and balanced, multilateral growth in his personal life.

Before proceeding to report the conduct and findings of this inquiry, it is necessary to clarify the specific objectives toward which it was directed and the frame of reference within which it was conducted. In the following chapters three preliminary questions are considered with a view to circumscribing the area of study and to establish the conceptual framework adopted for the purpose of this study.

(1) Chapter 2 establishes the historical background to this project, and examines the extent of existing knowledge prior to its inception, and delineates the field of study investigated here.

(2) Chapter 3 is devoted to consideration of the nature and meaning of health and illness, and formulates the basic criteria of health adopted for the purposes of this investigation.

(3) Then Chapter 4 describes the construction and procedure of the methodology employed in the conduct of this inquiry.

CHAPTER 2HISTORICAL AND RESEARCH BACKGROUND

It became evident from the outset that little was known of the health of Church of Scotland ministers in terms of empirical fact. Limited information was readily available. An assiduous search by the author unearthed no previous research into any aspects of the health of this group of clergymen.

The paucity of research into this subject applies not only to Scotland but to Britain in general. As far as can be determined, only two studies have been conducted in this country which have a direct bearing on the health of clergymen (Lake, 1966: A'Brook et al 1969).⁽¹⁾ Both are very recent and are principally concerned with the mental health of Anglican clergymen. The major source of data on the health of clergymen in Britain is the decennial reports on occupational mortality provided by the Registrars General for England and Wales and for Scotland. But, even though these reports contain valuable information, it seems that little use has been made of them with respect to the health of British clergymen.

Despite the inadequacy of available data, two generally held suppositions emerged from discussions about the health of Church of Scotland ministers. The first of these popular beliefs is that there has been a long-standing association between the Church of Scotland ministry and a relatively high degree of health. These ministers have long been credited with notable longevity by comparison

(1) F. Lake, Clinical Theology (Darton, Longman & Todd, U.K. 1966), p. 926 ff., in which he reports his diagnoses and findings on his last 100 clergy patients, most of whom were Anglican clergymen; and M.F.A'Brook, J.D. Hailstone, and I.E.J. McLauchlan, "Psychiatric illness in clergy", The British Journal of Psychiatry, April 1969, 115, 521, p. 457-463, which is comparable to an identical study on psychiatric illness in doctors published by the same authors (1967).

with other occupational groups, and the inference has been that this longevity is an indication of a favourable measure of health. All the signs suggest that the health of its ministers has been generally assumed within the Church of Scotland until very recent years; and in so far as mortality data provides a measure of health in a group, this confidence appears to be justified.⁽¹⁾ However, this association of the ministry with health has been challenged in the last two decades.

The second popular supposition to emerge is that the health of this group of clergymen has deteriorated appreciably in the post-war era. It has been claimed that this decline is evident in a rising death rate and reduced life expectation, in an increasing frequency of deaths from coronary heart disease, and in increasing strain and nervous breakdowns among ministers. Any such doubts which have been expressed publicly have been supported by minimal evidence and appear to have been based upon intuitive speculation and general impressions. No systematic research has been conducted which would substantiate the case one way or another. Nevertheless, there have been signs of growing concern and in view of the serious implications of these claims systematic research is a worthwhile undertaking.

An introductory survey of the historical background, relevant hypotheses, and research findings serves to clarify the major issues involved and to identify the specific propositions to which this investigation was directed.

NINETEENTH CENTURY BACKGROUND

The view that clergymen enjoyed a comparatively favourable degree of health was apparently established and confirmed within

(1) Some insurance companies have been known to offer these ministers special premium rates, and at least one still does so, because of their favourable actuarial rating and expected longevity.



Europe during the 19th century. On the Continent several eminent demographers and vital statisticians were interested in the possible relationship between the nature and conditions of a man's work and his experience of health and illness. Occupation was studied as one factor which could influence health in significant ways. One conclusion to emerge from such studies was that protestant clergymen enjoyed remarkable health in so far as length of life demonstrates health.

In 1835, Quetelet, a Flemish demographer, produced evidence from Brussels and Berlin which appeared to justify this conclusion.⁽¹⁾ With reference to the work of his German contemporary, Casper, he stated:

"Casper finds that the profession of medicine is more exposed than any other, contrary to the prejudices so generally received; and he observes that clergymen occupy the other extreme!"⁽²⁾

He also reported that of 100 clergymen (théologians)⁽³⁾ 42 attained the age of 70 years or more compared with 24 of 100 physicians. These two occupations represented the extremes for the selected occupations listed by Quetelet. From the evidence he concluded:

"It would seem to follow from this, that mental labour is more injurious to man than bodily, but that the most injurious state is that where fatigue of body is joined to that of mind. A sedentary life, which is not exposed to any kind of excess appears on the contrary to be most favourable!"⁽⁴⁾

(1) A.J. Quetelet (1835) A. Treatise on Man and the Development of His Faculties, (Edinburgh, 1842). (Sur L'Homme, et le Developpment de ses Facultés, Paris, 1835).

(2) Ibid., p. 40.

(3) Quetelet applied the term "théologians" to all Protestant clergy, academic and parochial.

(4) Quetelet, op.cit., p. 40.

Caution should be exercised in attaching too great importance to Quetelet's observations in view of the small populations involved. However, it is interesting to note that, within the context of 19th century Europe, he associated the ministry with relative health and that he identified the ministry with a sedentary life, free from undue mental or physical stress, and protected from "any kind of excess". With reference to the work of Lombard in Geneva he also observed that clergymen had a relatively low rate of death from "pulmonary phthisis"⁽¹⁾ which was a major cause of death at that time.

Later in the century, statistical studies conducted by P. Foissac (1873) in France confirmed the findings of Casper, Lombard and Quetelet.⁽²⁾ In analysing Casper's figures he found that clergymen had a life expectation of 65.1 years compared with 56.8 years for physicians.⁽³⁾ He also compared these figures with those compiled by Lombard in Switzerland and established that clergymen experienced a consistently high standard of health in various parts of Europe.⁽⁴⁾ Foissac quoted data from Germany, Belgium, France, and Switzerland and in every case clergymen ranked above the other professions and occupations listed. So a clear view emerged that clergymen experienced notable longevity and were, therefore, a relatively healthy group and it was suggested that this was attributable to their quiet, orderly, sedentary, stress-free way of life.

Contemporary data seemed to indicate that the experience of

(1) Quetelet, op.cit., p. 37.

(2) P. Foissac (1873), La Longévité Humaine (Bailliere, Paris, 1873).

(3) Ibid., p. 317.

(4) Ibid., p. 318.

Catholic religious was less favourable and nearer to expectations for the general male population. For instance, a comparable study had been conducted almost a century earlier by Deparcieux (1746) which examined the death rates of monks and nuns in and about Paris.⁽¹⁾ He found that the average length of life of nuns was longer than that of the general population while the death rate of monks was slightly higher than that of other men. In examining Deparcieux' figures a century later, William Farr (1850) Registrar General for England and Wales observed:

"The excess mortality of monks is considerable when compared to other groups living at the time..... The conditions of these members of religious houses is at all times peculiar and besides their vows of chastity involves a peculiar discipline likely to affect their lives. It is held generally that the suppression of a physiological function is prejudicial to health."⁽²⁾

It is questionable whether Farr had sufficient evidence to warrant such a conclusion and his observation is purely hypothetical, if not prejudiced. This suspicion is supported by the fact that the two factors which Farr isolated, chastity and discipline, applied equally to nuns and yet their length of life exceeded that of other women. Be that as it may, Farr's observation expresses a view which was gaining great prominence at the time; that is, that the nature and conditions of a man's work may have a considerable bearing on his health.

These fragments of statistical data, collected and analysed by European demographers in the 19th Century appear to have been

(1) Referred to by C.J. Fecher, J., "Mortality and morbidity studies of religious", Linacre Quarterly, November 1960, p. 157 f., and "Health of the religious clergy", Review for Religious, Vol. 23 1964, p. 316 f.

(2) Quoted by C.J. Fecher, (1964), op.cit., p. 316f.

influential in establishing the view that Protestant clergymen enjoyed a favourable health experience. There seems to be no question that they experienced great longevity than the male population and most other occupations. This association between the ministry and health has persisted in popular opinion. It has certainly never been seriously questioned or challenged in Scotland until very recent times.

TWENTIETH CENTURY DEVELOPMENTS: OCCUPATIONAL MORTALITY

The field of social and occupational medicine has grown and become increasingly sophisticated in this century and has built on the foundations laid by these pioneers in vital statistics. The principal source of data on occupational mortality, rates of death, longevity, and causes of death, are the decennial reports on occupational mortality compiled by the Registrar General for England and Wales. These have been complemented by similar reports made by the Registrar General for Scotland.⁽¹⁾ In general terms, the data contained in these reports confirmed and reinforced the association between the ministry and health established in the 19th Century.

(a) England and Wales

The Registrar General's report on occupational mortality for 1930-32⁽²⁾ included three main categories of clergymen in the Professional Order⁽³⁾: Anglican clergymen, Catholic priests and monks, and Ministers of other religious bodies. A related but numerically small group were itinerant preachers, missionaries and

(1) The salient features of these reports are summarized here. But in view of their relevance for this study they are examined in detail in Part III: THE MINISTRY AND HEALTH - STATISTICAL DATA.

(2) Registrar General for England and Wales, The Registrar General's Decennial Supplement, England and Wales 1931: Part IIa Occupational Mortality (H.M.S.O. 1938).

(3) Ibid., p. 136 f.

social workers.

From the details of this report it emerges that the experience of Anglican clergymen and ministers was similar in most respects and both groups apparently enjoyed unusually favourable health compared with the male population and with other professions. Both experienced a relatively high life expectation, with Anglican clergymen having a slight advantage over other ministers. The death rate of Anglican clergy was more than 30 per cent (S.M.R. 69)⁽¹⁾ below the male average and compared favourably with the entire Professional Order (S.M.R. 84). The only professional group to compare with the low death rate of these clergymen were teachers (S.M.R. 68), whose death rate was marginally below that of Anglican clergymen. By contrast, engineers were close to the professional average, judges and solicitors were close to the male average, and physicians and surgeons were above the average rate of death for the male population. It also appears that Catholic clergy (S.M.R. 105) were shorter lived on average than the male population in general. But as Fecher points out, this figure was based on a statistically small population and may therefore be unreliable.⁽²⁾

In terms of occupational death rates and length of life, this English data appeared to reaffirm the established association between the ministry and health. Anglican clergy and other Protestant ministers had a comparatively high length of life, matched only by teachers in the Professional Order, which is indicative of a relatively high degree of health.

(1) The Registrar General's Decennial Supplement, op.cit. Note: S.M.R. abbreviation for Standardised Mortality Ratio, which provides a comparison of the death rate of particular groups with that of the male population. The average death rate for the standardised male population = 100.

(2) C.J. Fecher (1964), op.cit., p. 317.

An examination of the principal causes of death provides further evidence of their comparatively favourable health. The only cause of death for which their experience was appreciably in excess of expectations was angina pectoris (or coronary heart disease). However, this phenomenon was evident, in varying degrees, throughout the professional order. Deaths from this disease within the medical profession (S.M.R. 368) were far in excess of the male average and were 64 per cent above the ratio for all occupations classified in Social Class I⁽¹⁾. Anglican clergymen, similarly, had a high rate of death from coronary heart disease (S.M.R. 218) and it was noted that other ministers probably experienced a significant excess of deaths from this disease. Teachers and engineers, by comparison, had lower rates of death from angina pectoris but were, nevertheless, well above the male average.

This was the most disturbing feature of the mortality experience of Anglican clergymen and other ministers in England and Wales at that time, one which they shared in common with other professions. The Registrar General offered an analysis of the incidence of principal causes of death according to five Social Classes⁽²⁾ and it was demonstrated that coronary heart disease varied considerably according to socio-economic status, being most prevalent in Social Class I and showing a marked gradient down to Class V.⁽³⁾ The apparent correlation

(1) Registrar General for England and Wales (1938), *op.cit.*, p. 76.

(2) *Ibid.*, p. 19 ff. and p. 30 ff.

(3) *Ibid.* Other causes of death to show a similar though less marked gradient from Class I down to Class V were leukaemia, disseminated sclerosis, endocarditis, and appendicitis. Reverse gradients, from Class I up to Class V, were shown for valvular heart disease, myocardial disease, respiratory diseases and bronchitis.

between coronary heart disease and socio-economic status revealed by this data aroused much interest and has since been subjected to careful examination. Extensive research has been conducted employing occupational and social data in attempts to identify the causes of this disease.⁽¹⁾ Such research has obvious relevance for any investigation into the health of clergymen; but as yet the results are far from conclusive and coronary heart disease remains something of an enigma.⁽²⁾

More positively, the mortality experience of Anglican clergymen and other Protestant ministers was well below expectations for all other major causes of death. This was most marked with respect to deaths from cancer, respiratory disease, and tuberculosis. In fact, Anglican clergy had the lowest rate of death among eightysix selected occupations for each of these diseases, while other ministers had an equally low rate of death from respiratory diseases and were second only to their Anglican colleagues for respiratory tuberculosis. As far as could be determined from the small numbers recorded, Anglican clergymen and teachers were also well below expectations for suicidal deaths. By comparison, other ministers and medical practitioners were a little above expectations and members of the legal profession had an extremely high rate of death by suicide.

The effect of this report was to reinforce the impression that the ministry was then associated with a relatively high degree of health. By comparison with the male population and other professions, Protestant clergymen in England and Wales during the early 1930s enjoyed a high

(1) R.U. Marks, "Factors involving social and demographic characteristics; a review of empirical findings," Millbank Memorial Fund Quarterly, April 1967, Vol. XLV, No. 2, provides a valuable survey of research into the causes of coronary disease.

(2) Ibid., p. 87.

average length of life and low rates of death from most principal causes of death. The only disturbing feature was the high incidence of angina pectoris among them, which applied in varying degrees to all professional groups. The only professional group to match and in some respects to exceed their experience were teachers.

The next decennial supplement on occupational mortality provided by the Registrar General for England and Wales was for the period 1949-1953.⁽¹⁾ It is not possible to make a direct comparison between this report and the earlier data. Some modifications had been made to the classifications of diseases and occupations. Moreover, important changes had occurred in the mortality experience of the male population and it should be remembered that all the data in these reports is relative to the average. However, in the general terms, basically the same features emerged.

The life expectation of Anglican clergymen (S.M.R. 81) and other ministers (S.M.R. 78) remained higher than expected, although they were nearer to the average (or the average was higher).⁽²⁾ Their positions had been reversed since 1930-1932, with other ministers having slightly greater length of life. Among the professions, teachers continued to have a comparable length of life. The average length of life of those in the medical (S.M.R. 89) and legal (S.M.R. 88) professions had evidently improved but was still below that of Protestant clergymen. By contrast, Catholic religious

(1) Registrar General for England and Wales, The Registrar General's Decennial Supplement, England and Wales 1951: Part II Occupational Mortality, Vol. 1. Commentary (H.M.S.O. 1958).

(2) It should be remembered that an S.M.R. is relative to the average and the male life expectation had been extended in this time.

(S.M.R. 107) continued to have a rate of death a little above the average.

The prevalence of the principal causes of death in these professional groups also presented a similar pattern to that established by the earlier report. Coronary disease,⁽¹⁾ which had been steadily increasing as a cause of death in the male population, continued to be a serious hazard for all professional groups and each was clearly in excess of the average: Anglican clergymen (S.M.R. 189), other ministers (S.M.R. 167), Catholic religious (S.M.R. 180), judges, etc. (S.M.R. 138), physicians, etc. (S.M.R. 179), and teachers (S.M.R. 162).⁽²⁾ These ratios are lower than those for 1930-1932, but the average incidence of coronary disease had risen appreciably in the interval. In common with other professions, deaths from vascular lesions affecting the central nervous system and from hypertension had become more frequent and were higher for both groups of Protestant clergymen. However, the prevalence of respiratory tuberculosis, cancer of the lung, bronchitis and pneumonia remained relatively low for all groups of clergymen. The frequency of suicide showed marked variations among the professions: Anglicans (S.M.R. 57), other ministers (S.M.R. 64), Catholic religious (S.M.R. 19), judges, etc. (S.M.R. 213), physicians, etc. (S.M.R. 254), and teachers (S.M.R. 136). The frequency of death by suicide had apparently declined among the Protestant ministers but had risen appreciably in the legal, medical, and teaching professions.

Hence, although their experience was statistically nearer to the average in most respects, the mortality experience of clergymen

(1) Reg. Gen. for England and Wales (1958), op.cit., p. 152.

(2) These ratios are for ages 20-64 years.

in England and Wales had undergone no significant change between 1931 and 1951. Their life expectation remained relatively high, and, even though vascular lesions affecting the central nervous system and hypertension had become more frequent, the only cause of death to be greatly in excess of expectations was coronary heart disease.

(b) Scotland

The English data has been complemented by similar reports on occupational mortality compiled by the Registrar General for Scotland.⁽¹⁾ A direct comparison cannot be made between these and the English reports because, as one would expect, the Scottish male "average" differs from the "average" for England and Wales. Also, the Scottish data is based on much smaller population figures which reduces the reliability of any statistical analysis. Moreover, clergymen of all denominations are blocked together, because of their comparatively small numbers, to constitute one occupational order: Ministers, Clergymen and Religious Orders. Therefore, denominational differences cannot be determined from these reports. However, the Scottish data seems to indicate that Scottish clergymen have had a mortality experience closely parallel to that of their English counterparts and added further weight to the association between the ministry and health.

In the period 1930-1932,⁽²⁾ the Professional Order (S.M.R. 92.9) in Scotland had a less marked advantage over the average male death

(1) In view of their particular relevance for this study these Scottish reports will be examined in detail in Part III: The Ministry and Health - Statistical Data.

(2) Registrar General for Scotland, Supplement to the 78th Annual Report (1931) of the Registrar General for Scotland: Part II General Tables (H.M.S.O. 1936)

rate than was evident in the English figures and of the professions teachers (S.M.R. 82.6) had the most favourable experience. The length of life of Scottish clergymen (S.M.R. 95.9) for all ages over 15 years was a little above average, but was below the professional average. Their death rate for ages 25-44 (S.M.R. 62) showed a clear advantage over the male population, as did that of solicitors (S.M.R. 41) and teachers (S.M.R. 68). However, the death rate of Scottish clergy rose steadily for all ages over 44 years to be close to average for all ages. The death rate of solicitors rose even more dramatically to be in excess of expectations for all ages (S.M.R. 103.7). Physicians were close to average (S.M.R. 103.5) at all ages.

In common with their English counterparts, Scottish clergymen experienced low rates of death from respiratory tuberculosis (S.M.R. 31), from bronchitis and pneumonia (S.M.R. 51), and a comparatively low rate of death from cancer (S.M.R. 81). The incidence of various respiratory diseases was low for all professional groups, but was clearly lowest in the experience of clergymen closely followed by teachers. Although all forms of heart disease were the greatest cause of death for the male population and for each professional group, this report contained no details on the incidence of coronary heart disease to compare with the English data for the period. But it may be significant that a higher proportion of deaths among clergymen (27%) were due to all forms of heart disease than for the male population (18%), as was true for all the professions.⁽¹⁾

The Scottish pattern of occupational mortality, in so far as

(1) For details refer to Registrar General for Scotland (1936), op.cit., p. xlv ff.

the professions are concerned, was similar twenty years later when the Registrar General's report for 1949-1953 was published.⁽¹⁾ Clergymen still enjoyed a greater length of life (S.M.R. 88.3) than the male population and their position had improved relative to the average. As the life expectation of Scottish males had been extended it is reasonable to conclude that clergymen's length of life had been further extended since the earlier period. Once again teachers (S.M.R. 80.7) had a lower rate of death, as did scientists (S.M.R. 84.9), who were included as an occupational order for the first time. The life expectation of those in the legal and medical professions was still below average and did not show the improvement experienced by their colleagues in England and Wales during the same period.⁽²⁾

The frequency of the principal causes of death among the professions was again similar to the earlier report. It seems typical that most professional groups have had consistently low rates of death from all kinds of respiratory diseases, an experience which has been shared by clergymen. In each of these reports the incidence of cancer as a cause of death reveals unusual and unexpected occupational variations. The frequency of deaths from malignant neoplasms, which has been steadily rising, is characteristically clustered around the average (i.e. 80-120) with no marked occupational variations. But, in every report, teachers and clergymen have always been among those with the lowest death rates from cancer as is highlighted by the Scottish figures for 1949-1953.⁽³⁾ Clergymen (S.M.R. 71) and teachers (S.M.R. 72) had unusually low rates of death from cancer,

(1) Registrar General for Scotland, Annual Report of the Registrar General for Scotland 1955, No. 101 Appendix IX, Occupational Mortality (H.M.S.O. 1956).

(2) Ibid., p. 76. Also refer to Tables p. 82-133.

(3) Ibid., p. 78.

while physicians, solicitors, and engineers were close to or in excess of expectations. There is no obvious explanation for this marked variation but the incidence of cancer of the respiratory system may provide a clue: clergymen (S.M.R. 48), teachers (S.M.R. 53), physicians (S.M.R. 103), solicitors (S.M.R. 116), and scientists (S.M.R. 111).

In this report the Registrar General provided details on the occupational mortality ratios for coronary heart disease and this data provided a marked contrast to the English information. It was reported that deaths from coronary heart disease had been rising steadily, especially in the male population,⁽¹⁾ and in general, the distribution of this disease is similar to the pattern established by the English reports, with occupations in Social Class I having the highest rates of death from coronary disease.⁽²⁾ But the over-all range of mortality is much less in the Scottish figures. For occupational orders, the frequency of deaths from coronary disease was highest among Administrators and Directors (S.M.R. 152), the Commercial, Financial and Insurance Order (S.M.R. 141), followed by the Professional Order (S.M.R. 134); and for individual occupational groups it was most frequent among company directors and stockbrokers (S.M.R. 196) and physicians (S.M.R. 158). By contrast with the English data, however, several occupations in Class I had mortality ratios close to or below the male average, including clergymen (S.M.R. 106), teachers (S.M.R. 90), scientists (S.M.R. 84), and local authority officials (S.M.R. 100).⁽³⁾ This illustrates how generalisations about social class may be misleading.

(1) Registrar General for Scotland (1956), op.cit., p. 78.

(2) Ibid., p. 78 and p. 81.

(3) Ibid., p. 78.

On the surface, these figures suggest Scottish clergymen were less vulnerable to coronary heart disease than their English counterparts. As a matter of fact, it has been argued (S.L. Morrison, 1957) that a comparison between these figures and the English data for 1930 - 1932 indicates a significant reduction in the prevalence of this disease among Scottish clergymen and teachers.⁽¹⁾ But Morrison's argument is not entirely convincing. In particular, it assumes that the experience of Scottish clergymen in 1930 - 1932 corresponded with that of their English colleagues. Moreover, closer examination reveals a marked increase of coronary disease among Scottish clergymen and teachers over the age of 65 years. Among clergymen the ratio of deaths was a little above average for ages 15-64 years (S.M.R. 106) but then rose to be well in excess (S.M.R. 130) for all ages. The same applied to teachers with S.M.R. 90 for ages 15-64 years rising to S.M.R. 116 for all ages. Therefore, although the experience of both groups was closer to average than that of their English counterparts, it seems clear that the incidence of coronary disease among clergymen and teachers increased significantly above the age of 65 years. Whatever the facts, each of these reports indicate the significance of coronary heart disease as a cause of death for British clergymen and this phenomenon will require closer examination.

At this stage three tentative conclusions emerge from the British mortality data.

1. British clergymen, with the exception of Catholic religious, have apparently enjoyed greater longevity than the male population and than most other professional groups at least up until the early

(1) S.L. Morrison, "Occupational mortality in Scotland". British Journal of Industrial Medicine, April, 1957, 14 (2).

1950s. Only teachers, among the professions, have consistently experienced greater longevity. The advantage of clergymen over the male population was greatest up to the age of 45 years and thereafter their death rate rose steadily to be close to average at 65 years. On the basis of the English data, Catholic religious were shorter lived than the male population in general.

2. In terms of life expectation, Scottish clergymen had a less marked advantage over the general population than their English counterparts, especially in the 1930 - 1932 period. However, they enjoyed a greater advantage over the average in the later period and, as the male average had been extended in the interval, it is safe to assume that the life expectation of Scottish clergymen had been further extended.

3. The only major cause of death for which the experience of clergymen was appreciably in excess of expectations was coronary heart disease (angina pectoris). This was most evident in the English data and the incidence of mortality from this disease may not have been so excessive among Scottish clergymen. On the positive side, the frequency of all other principal causes of death, including respiratory tuberculosis, bronchitis and pneumonia, other respiratory diseases, and all forms of cancer, especially cancer of the respiratory system, was comparatively low among British clergymen over this twenty year period.

The general impression conveyed by this British occupational mortality data seems to justify the long-standing confidence in the health of clergymen in this country. All the sources extending over more than a century up to the post-war decade presented a consistently favourable picture, which possibly accounts for the lack of research in this country. But whether this good record has been maintained

has become the subject of contention and it is questionable whether the association between the ministry and health can be assumed any longer.

A period of eighteen years have now elapsed since the last British occupational mortality reports and important changes may have occurred in the interval. No up-to-date information is available as yet, although it is understood that reports for the five years around 1961 are being compiled and may soon be published. The only group of clergy to be the subject of continuing mortality studies are Catholic religious in U.S.A. (Fecher, 1960: 1964).⁽¹⁾ The only other material with reference to the mortality experience of clergymen has been contained in occasional actuarial investigations conducted by insurance companies and isolated mortality studies. In most cases these confirm the general conclusions that Protestant clergymen have and do enjoy relatively high longevity and favourable health in Western Societies.⁽²⁾

While it is reasonable to suppose that the British occupational mortality data provides a general indication of their health experience, it cannot be determined how far this information is applicable to the

- (1) C.J. Fecher (1960 and 1964), op.cit. The reports made by the Registrar General for England and Wales indicated that Catholic religious were shorter-lived than the general population and other professional men. But these studies have demonstrated a steady increase in the average length of life of Catholic religious in the U.S.A. in this century. Fecher reported that "the life span of a priest or brother in a religious community is longer than that of a layman in the world" (1964, p. 316) and that their life expectation at 20 years had been extended by 8 years compared with $7\frac{1}{2}$ years for men in other professions between 1905 and 1950 (1964, p. 321). But he also reported that there was a very steep rise in their mortality over the age of 35 years until it approximated the male average at 50 years (1964, p. 323).
- (2) For example, a report in the Statistical Bulletin of the Metropolitan Life Insurance Co. Ltd., New York, Jan. 1968, 49, found that clergy and church officials listed in Who's Who (U.S.A.) were longer lived than all others listed and that all clergy in the 45-64 age group experienced lower mortality than all those in similar professions.

experience of Church of Scotland ministers. This is an unknown quantity. Most studies have shown that groups of Protestant clergymen usually have a favourable experience. But these studies have also revealed marked denominational variations and have shown that the mortality of different groups of clergymen varies appreciably according to faith and denomination, race, marital status, ministerial specialities, geographical location and socio-cultural environment. This fact is borne out by a recent study of mortality among ministers of the United Lutheran Church in America (King and Bailer, 1968).⁽¹⁾ The findings of this study corroborated the existing evidence of the low mortality of Protestant clergymen. But it also emerged that the death rate of Lutheran ministers was substantially lower than that of all white clergymen in the United States and was only half that experienced by other white clergymen in the age group 20 to 64 years. It was further demonstrated that their experience of major causes of death differed appreciably from that of Anglican clergymen in England and Wales. Such marked denominational variations demonstrate the necessity of regarding each group of clergymen as particular cases.

However, the broad outline suggested by the British reports, corroborated by studies conducted elsewhere, has been influential in supporting and reinforcing the association between the ministry and health which was established in the context of Nineteenth Century Europe.

RECENT DEVELOPMENTS IN SCOTLAND

As far as the Church of Scotland is concerned it would seem that the health of its ministers has long been taken for granted. Perhaps

(1) H. King and J.C. Bailer, "Mortality among Lutheran clergymen", The Millbank Memorial Fund Quarterly, Vol. XLVI, No. 4, Oct. 1968.

this assumption is not without justification, especially in view of the encouraging picture presented by the British occupational mortality reports. However, the health of its ministers has become the subject of some concern in recent years. Fears that their health may have suffered have been expressed sporadically over a period of twenty five years. But only in the last decade or a little more have such fears become overt and explicit.

Up until the mid-1950s only isolated references were made to the health of this group of ministers and, in general, aroused little interest or concern. The health of its ministers was alluded to by a General Assembly committee as early as 1942. This was done in an oblique manner when the inadequacy of existing provisions for the pastoral care of ministers was brought to the attention of the Assembly by a special Committee for the Interpretation of God's Will in the Present Crisis.⁽¹⁾ Over the next five years this issue had a prominent place in the Assembly's deliberations.

In a forthright appraisal of the Church's life and organisation, the Commission paid special attention to every aspect of the ministry and was particularly critical of the lack of care of ministers once ordained. In the absence of effective pastoral supervision, the Commission considered ministers were left to rely on their individual resources in relative isolation and stated: "a young minister..... often finds himself in a position of almost complete independence at the very time when he stands most in need of wise counsel and kindly oversight."⁽²⁾ The Commission doubted whether a Presbytery,

(1) Reports to the General Assembly of the Church of Scotland 1942, p. 574 ff. This Commission submitted annual reports from 1942 to 1946. Note: hereafter such reports will be referred to as "Reports to the G.A. .."

(2) Ibid., p. 579

as a corporate body, could ever occupy "a pastoral and confidential relation" to individual ministers and recommended the adoption of a scheme of personal supervision to meet this end.

The vast majority of Presbyteries shared the Commission's estimate of the inadequacy and inefficiency of existing provisions for the care of ministers⁽¹⁾ and the Commission then proposed the adoption of a system of personal supervision exercised by permanent Moderators of Synods whose functions would include acting as "Counsellors to ministers".⁽²⁾ However, this recommendation was decisively rejected in the following year and no alternative was offered or considered.⁽³⁾ The Commission expressed the opinion that the vital issue had been confused by prejudice⁽⁴⁾ and observed: "It is inconceivable that having admitted this inadequacy, the Church should continue to acquiesce in it."⁽⁵⁾ But there the matter was allowed to rest and it can only be assumed that concern for the well-being of ministers was not sufficiently urgent at that point to stimulate action.

Through the immediate post-war decade the Church of Scotland, in common with all public services, was confronted with new and changing conditions necessitating reappraisal and readjustment of almost every aspect of its organisation and work. The problems of adapting to the exigencies created by the programme of national reconstruction are evident in numerous reports to the General Assembly

(1) Reports to the G.A., 1943, p. 449.

(2) Reports to the G.A., 1944, p. 515.

(3) Reports to the G.A., 1945, p. 469.

(4) *Ibid.*, p. 470.

(5) *Ibid.*, p. 472.

during the period 1945 to 1956. In particular, the established parochial system and the traditional pattern of one-man ministries came under the review of several committees faced with the problem of adapting the Church's organisation to very different socio-cultural conditions.

In contending with the need to adjust to shifting population centres while coping with a serious man-power shortage,⁽¹⁾ the Church of Scotland was forced to re-evaluate and reorganise its overall policy, strategy and procedure with respect to the ministry. But it is curious that through this period of rethinking and reorganisation the only aspect of the minister's life and work which received little or no attention was his personal health and well-being. Apparently this was taken for granted, supported by meagre but reassuring information contained in actuarial reports presented to the Assembly by the Aged and Infirm Ministers' Fund Committee.⁽²⁾

The actuarial reports during this period were reassuring. Reporting on mortality experience for 1942 - 1947, the actuary found that both retirements and deaths among contributors to the pension fund had been fewer than expected.⁽³⁾ The fewer retirements were attributed

- (1) The seriousness of the emerging manpower crisis was fully exposed in a report by a special committee Anent the Use of the Ministerial Resources of the Church, Reports to the G.A., 1948, p. 527 ff. The subject has been taken up by a number of committees since then and will be referred to in more detail in Part II: The Minister's World.
- (2) Actuarial investigations have been made on behalf of the Aged and Infirm Ministers' Fund Committee at five yearly intervals. However, membership of the fund was voluntary until 1958, so that investigations up to that time only refer to those ministers who contributed. The information presented in these reports will be considered in detail in Part III: The Ministry and Health - Statistical Data.
- (3) Reports to the G.A., 1948, p. 114.

to the fact that some ministers were reluctant to retire at the official age of 70 years after 40 years service due to the financial burden this would impose on their congregations.⁽¹⁾ A new scheme was then introduced with a view to alleviating the burden on congregations and to enable ministers to retire with a clear conscience.⁽²⁾ The actuary predicted lighter mortality and higher retirals following the adoption of this scheme.

The following report for 1948 - 1952 was similarly encouraging and further bolstered confidence in the health of ministers. The actuary stated that pensioners "have shown a marked vitality and deaths among them were fewer than expected."⁽³⁾ The mortality experience of active ministers was not mentioned but, although these reports applied only to voluntary contributors to the pension fund, the over-all impression was positive and suggested that the health of ministers required no special attention. The actuary again predicted an increase in the rate of retirement and a decrease in the mortality of pensioners with wider acceptance of the pension scheme introduced in 1948.

However, the picture began to change significantly in the next few years and the actuary's predictions were not fulfilled. The first indication of a possible change was unexpected and came in an indirect form.

- (1) According to the regulations in effect at that time a proportion of the retiring minister's annuity was derived from 15 per cent of the stipend provided by his congregation. This imposed a sizable burden on the congregation's resources and sometimes the stipend for the retiring minister's successor had to be reduced.
- (2) In the new scheme, known as Scheme A, congregations had the option of making an annual contribution to the fund equal to $2\frac{1}{2}$ per cent of the stipend rather than paying a large lump sum on the retiral of a minister. The majority had adopted this scheme by 1954.
- (3) Reports to the G.A., 1953, p. 133.

In 1954 the Education for the Ministry Committee presented an extensive analysis of the reasons for the continuing and critical shortage of candidates for the ministry which confronted the Church of Scotland at that time.⁽¹⁾ Among the many reasons put forward, the Committee maintained that some young men were deterred by the negative image of the ministry, by the time which ministers evidently have to waste on trivia, by pessimism within the Church, and by the defeatist attitudes of some ministers "because they know that some who have not long been in the ministry have grown despondent and frustrated, even seriously doubting their calling."⁽²⁾ In the opinion of the Committee feelings and attitudes of pessimism, despondency, frustration and failure were apparent within the Church and among ministers, but expanded this no further. Evidently the pressure of adapting to the conditions of socio-cultural change was being felt throughout the Church and was possibly affecting the psychological and emotional well-being of ministers. However, intriguing though it is, this hint at despondency and frustration among ministers was not elaborated and received little attention.

The General Assembly was then confronted with information which could not be ignored and which made it impossible to assume the health of ministers any longer. In 1956, although the mortality of contributors to the pension fund had "approximated closely" the previous valuation during the period 1952 - 1955, the actuary reported an unusual and unexpected development.⁽³⁾ Deaths in the 70-74 age group,

(1) Reports to the G.A., 1954, p. 463 ff.

(2) Ibid., p. 464.

(3) Minutes of the Aged and Infirm Ministers' Fund Committee, April 17, 1956 (supplied by the Secretary, Rev. K. Greenlaw): the details of which were reported to the Commission of the General Assembly, October 1956.

immediately following official retiral age, had been "about 80 per cent in excess of normal for this age group".⁽¹⁾ The actuary ventured the opinion:

".....it seems to me not unlikely that many of our ministers carry on their work to age 70 when they really are not fit, and when they retire shortly after attaining three score years and ten the psychological effect of being relieved of the care of their flock may affect their will to live."⁽²⁾

The actuary's speculation about a possible relationship between the age of retirement and this increase in mortality was based on the purely circumstantial fact that this development followed the implementation of a pension scheme enabling ministers to retire more readily at 70 years. However, whatever the reasons, the lower mortality predicted by the actuary five years earlier had not eventuated and there had been a dramatic increase in deaths among ministers in the 70-74 age group.

A special actuarial investigation was undertaken in the following year and the Assembly was informed of a continuation and extension of this disturbing development.⁽³⁾ Deaths in the 70-74 age range continued to be higher than expected and for all ages over 70 years deaths were about 40 per cent in excess. In addition, however, there had been "a marked and substantial" rise in deaths in the 65-69 age group which were now double those expected. Below 65 years mortality was in the normal range. In seeking an explanation the actuary commented,

"One can only guess at the cause of this mortality, but it

(1) Ibid.

(2) Ibid.

(3) Reports to the G.A., 1958, p. 274 ff.

seems to me probable that the continued effects of prolonged stress in the ministry, the steep rise in the cost of living in the past few years, must both have had their effect on the health of ministers."⁽¹⁾

So the actuary now added prolonged stress and economic pressures to loss of motivation following retirement as possible causes for the sharp rise in deaths among Church of Scotland ministers in the 65-74 age group.

These reports seem to suggest that the health of this group of ministers declined substantially within the space of a few years. In so far as mortality data is indicative of a group's health, these ministers apparently enjoyed satisfactory health up to 65 years but thereafter their health deteriorated rapidly. Between 1953 and 1958 deaths had increased significantly in the 65-74 age group, that is, in the five years immediately preceding and following the official retiral age. This development coincided with many other changes in the nature and conditions of ministers' life and work and in the socio-cultural milieu in which they exercise their ministry. It is interesting to note that this development in Scotland also coincided with the increasing concern for the health of clergymen being expressed elsewhere at that time.⁽²⁾ One wonders whether such a widespread phenomenon, if it occurred, could be purely coincidental or whether common factors could not be involved.

The effect of these actuarial reports was to bring the health of ministers to the attention of the Assembly in explicit terms for the first time. Confronted with this information it was impossible for

(1) Reports to the G.A., 1958, op.cit., p. 275-6.

(2) q.v. Chapter 1.

the Church's administrative bodies and officials to avoid the issues involved. The following actuarial report, in 1964, offered no relief or encouragement. The actuary found that "the high rate of mortality among ministers in the years immediately preceding and immediately following the retiral age of seventy years" had continued, while mortality for other age groups was within expected limits.⁽¹⁾ There was therefore no sign of the decline being retarded or reversed.

Since then, motivated by the concern which these reports aroused, some steps have been taken to protect and promote the health and well-being of ministers. Their economic security has been maintained if not improved by the sustained efforts of committees in the Church and Ministry Department. The minimum stipend increased from £750 to £1200 per annum between 1960 and 1969, but, as the convenor of the Maintenance of the Ministry Committee stated at the 1969 General Assembly:

"The minimum stipend has kept pace with the cost of living over the years - just that and nothing more: there was nothing over. It has maintained the Ministry. Today it is just where it was in 1939 in terms of real money. The Church ought to be aware of that; and if it isn't aware, it must be informed."⁽²⁾

In the same period, 1960 to 1969, retirement provisions were greatly improved. The pension rate for ministers increased from an annuity of £300 to £600. In 1958 it became compulsory for all ordained ministers to contribute to the fund so that pension benefits were available to all ministers who had served a minimum period. The official, though not compulsory, retiral age was lowered in 1965

(1) Reports to the G.A., 1964, p. 213 ff.

(2) Life and Work, June 1969, p. 9.

to 65 years following a minimum of twenty years service, with a full annuity after forty years service.⁽¹⁾ Then in 1968 the minimum years of service before retirement were reduced to fifteen years to provide some benefit for late-entrants to the ministry and for those who had transferred from other denominations.⁽²⁾

The problem of providing pastoral care for ministers has not had a prominent place in the Assembly's deliberations since the controversy surrounding the proposed introduction of permanent Moderators of Synods was brought to a close in 1945. However, this important issue has received more attention in recent years. An ad hoc committee on Recruitment and Training for the Ministry reporting to the Assembly in 1969, almost a quarter of a century later, expressed the opinion that in many instances Presbyterian oversight and concern for students and probationers is superficial and unsatisfactory, and then called on Presbyteries "to ensure that concern for students is maintained throughout their whole period of education and training."⁽³⁾ At least one Presbytery has attempted an interesting and novel experiment in the exercise of pastoral care. In 1960 the Presbytery of Edinburgh appointed a panel of confidential Counsellors, comprising a senior minister, a university professor, and a leading layman, who could be consulted by any minister, elder, member of a congregation, Kirk Session or Board in any difficult or unsatisfactory situation.⁽⁴⁾ These Counsellors submit no official reports and their work is strictly

(1) Reports to the G.A., 1965, p. 161. The full regulations are to be found in the Reports to the G.A., 1966, p. 315 ff.

(2) Reports to the G.A., 1968, p. 325 ff. for the amended regulations.

(3) Reports to the G.A., 1969, p. 730 ff. and p. 740.

(4) The Presbytery of Edinburgh Year Book, 1970, pp. 62, 72.

confidential, so it is not known whether ministers are taking advantage of this opportunity, and to date the scheme has not been adopted by other Presbyteries.

Another development has been the introduction of Selection Schools to facilitate a more thorough evaluation of candidates' suitability for the ministry. The primary responsibility for evaluating and selecting candidates has traditionally rested on Presbyteries.⁽¹⁾ But in 1942 the Commission on the Interpretation of God's Will expressed the view that Presbyteries were not always taking effective measures "to discourage the entrance of those who have no real sense of vocation",⁽²⁾ and advised greater care in selection. Whether this advice stimulated Presbyteries to undertake anything more than a cursory examination of candidates is not known. In any event, the responsibility has been shared jointly between Presbyteries and a Central Board for the Selection and Supervision of Ministers, established in 1947,⁽³⁾ and in 1966 this Board introduced Selection Schools.⁽⁴⁾ A modification of the Extended Interview method has been employed as the basis of assessment, with each candidate participating in a series of interviews, a battery of written and oral tests, and group exercises, including an unstructured group experience.⁽⁵⁾ With the adoption of this procedure the Committee considered that "The glib and superficial are not so likely to impress.

(1) J.T. Cox (ed.), Practice and Procedure in the Church of Scotland (5th Edition, Blackwood & Sons, 1964), p. 208 ff.

(2) Reports to the G.A., 1942, p. 576.

(3) Practice and Procedure in the Church of Scotland, op.cit., p. 202-3.

(4) Reports to the G.A., 1967, p. 710.

(5) Reports to the G.A., 1969, p. 665-6.

A facade must be pretty good to withstand two days investigation."⁽¹⁾
 During 1968 eighty-three applicants participated in five such schools and of these sixty-four (i.e. 77 per cent) were recommended for acceptance. The Committee then found it necessary to take steps to ensure the "after-care" of those not accepted.⁽²⁾

It could reasonably be expected that each of these developments with respect to the maintenance, pastoral supervision, and selection of ministers would make some contribution to safe-guarding their standard of health. However, whether any marked improvement has occurred in the last few years is far from certain. Once again, contradictory and confusing reports and opinions have come forward.

The most recent actuarial report suggests an encouraging improvement in the five years up to 1968. According to the actuary, the high rate of death previously reported in the 65-74 age group is no longer evident and deaths among active and retired ministers "is somewhat lighter than at previous investigations."⁽³⁾ This would suggest a positive reduction in the over-all mortality experience of Church of Scotland ministers.

However, over against this, in a petition to the same Assembly seeking the introduction of Sabbatical Leave for ministers, it was claimed that there had been "an increase in strain, nervous breakdowns, and deaths from coronary thrombosis among ministers".⁽⁴⁾ The petitioner, acting on behalf of the Presbytery of Inverness, presented meagre evidence to support these claims but went on to assert:

(1) Reports to the G.A., 1967, p. 710.

(2) Reports to the G.A., 1969, p. 665.

(3) Ibid., p. 270-71.

(4) Life and Work, April, 1969, p. 20 ("A break for ministers").

"Once the ministry was synonymous with health, but now the pressures are so great at times ministers are not having enough time with their families, and not many children are following their fathers into the Church. Some men started with visions of zeal, but are now just working out their time. The mental effort and pace can make a man so ragged that he cannot sit still and pray. The flesh and blood and nerves rebel."⁽¹⁾

In face of these claims, the Assembly was asked to consider the introduction of Sabbatical Leave to provide ministers with a much needed opportunity "for refreshment and renewal every seven years, the period being perhaps three or six months."⁽²⁾

The petition makes reference to the long-standing and widely-held belief that there has been a close association between the ministry of the Church of Scotland and a relatively high degree of health. Certainly the health of its ministers has never been brought before the Assembly in such an explicit manner as an issue requiring urgent attention. It is also asserted that there has been a serious decline in the health of these ministers as evidenced by increasing strain, nervous breakdowns and deaths from coronary thrombosis, and that this deterioration has physical, mental, emotional, interpersonal and social manifestations. Almost no aspect of ministers' lives, it is argued, has been unaffected.

There is no question of the concern or sincerity with which the petition was brought forward. However, these claims were supported by a modicum of evidence which does not seem to justify such

(1) Life and Work, April, 1969, p. 20.

(2) Ibid.

comprehensive and disturbing conclusions.⁽¹⁾ The meagre evidence presented was inconclusive and was concerned solely with the frequency with which ministers in six Presbyteries have required extended leave of absence during the preceding three to five years.⁽²⁾ The claims made in the petition seem to have been formulated on the basis of personal observation and general impressions. Moreover, one wonders whether the recommended course of action, the introduction of Sabbatical Leave, would have the desired effect if it were implemented; but it does raise once again the whole issue of the adequacy and efficacy of existing provisions for the pastoral care of ministers in the Church of Scotland.

It is notable that this petition was received by an overwhelming majority and was referred to a standing committee of the Church, working in co-operation with other committees, for further consideration. It would seem, therefore, that the petition reflected widespread concern for the health of ministers within the Church of Scotland. If these claims have any foundation in fact then it would indicate a matter of serious concern for the Church's administrators, for those responsible for the selection, training and care of ministers, and for individual ministers themselves.

- (1) In making a critical evaluation of the petition's substance no criticism of the petitioner's concern or sincerity is implied or intended. It was inspired by genuine concern for the welfare of the Kirk's minister and the petitioner had gone to some pains to collect appropriate evidence. The petition was presented by Rev. A.C. Gibson, Nairn Old Parish, on behalf of the Presbytery of Inverness. Mr. Gibson readily supplied the details of his evidence to the author and his assistance is gratefully acknowledged.
- (2) Unfortunately no details were provided of the reasons for minister's seeking extended leave of absence and in presenting the petition it was assumed that health reasons were predominant. In fact, that is an unknown quantity. Further reference will be made to this information in Part III: The Ministry and Health - Statistical Data.

It is against this background of conflicting opinions and inconclusive evidence that this project has been conducted. The fundamental questions are whether Church of Scotland ministers have ever enjoyed the notable standard of health with which they have been popularly accredited and whether this record has suffered to any significant extent in recent years.

EMPIRICAL FINDINGS AND HYPOTHETICAL CONSIDERATIONS

The growing concern for the health of Church of Scotland ministers has been informed by scanty fragments of evidence, apparently supported by personal impressions and observations. Against this atmosphere of speculation, it is somewhat surprising that no thorough investigations have been previously conducted into any aspect of their health experience. The only reasonably reliable information is to be found in the Registrar General's reports and in the actuarial reports presented to the Assembly, and both have considerable limitations.

Three studies have been recently conducted in Scotland which make incidental references to factors which may have a bearing on the health of these ministers. A.V. Campbell (1967), studying the influence of personality, age, experience, denominational affiliation, beliefs and attitudes on the counselling methods of Scottish clergymen, found two distinctive personality characteristics.⁽¹⁾ The sample of Episcopal, Catholic, and Church of Scotland students and ministers were found to be "significantly more intropunitive than the population",⁽²⁾ which is

(1) A.V. Campbell, "The Influence of Counsellor Variables on Methods of Pastoral Counselling", unpublished Ph.D. dissertation, San Francisco Theological Seminary, U.S.A., 1967.

(2) Ibid., p. 101.

consistent with studies conducted elsewhere. Also, the Presbyterian ministers and students were unusually low on the neuroticism scale by comparison with English male norms according to the measures employed.⁽¹⁾ The facts revealed by this study, showing a tendency to be intro-punitive and a low measure of neuroticism, may prove to be significant with respect to the health of this group; but it should be noted that these results were obtained from a small sample population.⁽²⁾

Some information on the personality characteristics of Scottish theological students affiliated with Protestant denominations has been provided by a study of religious development and experience conducted by D.G. Hamilton (1968).⁽³⁾ In an analysis of personality factors, Hamilton found that theological students were atypical of the student population in a number of respects, being less intelligent, more tender-minded and sensitive, more dependent and less dominant, and having greater super ego-strength than their peers.⁽⁴⁾ The greatest deviation was evident in the premsiac factor which showed the theological students to be significantly more tender-minded than their fellow students.

A sociological study of the role and functions of Church of Scotland parish ministers in and around Aberdeen has been conducted by B. Anderson (1969), in which the attitude and work of ministers in the "Central Area" are compared with those in surrounding suburban

(1) A.V. Campbell, op.cit., p. 142-3.

(2) Total sample comprising 36 students and 18 clergy. The Church of Scotland sample comprised one-third of the total.

(3) D.G. Hamilton, "An Exploratory Study of Religious Experience and Development", M.A., Glasgow, 1968.

(4) The Cattell 16 P.F. Personality Inventory, Form C was employed for the purposes of measurement.

parishes. (1) Anderson reports that these ministers do not possess a clear role-definition or job-description and, if anything, these ministers adopt a role which conforms to congregational expectations and in which they become engaged in diffuse activities without a focal thrust. In these conditions, lacking a definite professional role, ministers experience frustration arising out of an awareness of the discontinuity between the traditional institutional structure and the wider social structure. This is most true of ministers in the city-centre area where social and cultural change has had the greatest effects.

These studies raise important questions about the relationship between the minister's health, his personality, and his professional role, and we will have reason to refer back to them at a later stage. But they take us no further at this point, except to note the possibility of an unusually low neurotic tendency among Church of Scotland clergymen. Some broad guidelines do emerge from research conducted elsewhere.

REVIEW OF EMPIRICAL FINDINGS (2)

The findings of studies and research on the mental, emotional, and physical health of clergymen are in the main favourable. There was, as noted earlier, an immediate reaction to the somewhat dramatic and alarming claims expressed in the mid-1950's. Informed studies, especially in the United States, generally refuted these claims and

- (1) B. Anderson, "Central Area Study", submitted to the Church and Ministry Dept. of the Church of Scotland, 1969 (kindly supplied by the Department Secretary, Rev. K. Greenlaw).
- (2) Synopses of available research projects with details of authors, subjects, methods and findings are presented in Appendix I. Complete references to authors and publications are provided in the Bibliography.

led to a consensus of opinion that there had been no significant decline in the health of clergymen. There was no evidence of increased hospitalisation, breakdowns, or deaths among clergymen and illness among them was no greater than could be expected of any comparable occupational group (L. Morgan, 1958; S. Southard, 1958). No new evidence has come forward to suggest any appreciable deterioration in the interval.

(i) PHYSICAL HEALTH

As far as research is concerned, physical health has been the most neglected aspect of their health experience. But, as measured by mortality data, according to all the available evidence clergymen have and do enjoy an unusually favourable health record. In most instances they achieve notable longevity by comparison with other professions, teachers excepted, and deaths among them from most major causes of death are below expectations. The only disturbing feature has been the prevalence of coronary heart disease among clergymen and no explanation has been found for this phenomenon.

But, it should also be noted, marked denominational variations are apparent in such mortality data. For instance, the mortality rate of Lutheran ministers in the United States has been extraordinarily low by any standards (King and Bailar, 1968), while that of Catholic male religious has been only marginally below the professional average (Fecher, 1960; 1964). Furthermore, in contrast to the experience of Protestant clergymen in Britain, these two American groups have not experienced abnormal rates of death from coronary disease. However, with the proviso that allowance should be made for denominational variations, all such reports are generally positive.

(ii) MENTAL HEALTH

Most investigators have focussed their attention on mental

health and again the consensus of opinion is positive. As early as 1936 T.V. Moore, a notable forerunner in this field of inquiry, found that the total incidence of insanity among Catholic religious was much less than for the general population.⁽¹⁾ Fr. Moore also reported a high proportion of dementia praecox (schizophrenia) among hospitalised clergy compared with other psychiatric patients; but in general his subjects were less prone to psychiatric disorders than the population at large. As a matter of fact, an unusually high incidence of mental illness has not been reported for any group of clergymen and, on the basis of clinical experience, D. Blain (1953) observed, "most ministers have a high degree of mental health".⁽²⁾

Reports of increasing "breakdowns" among clergymen in the United States (Shrader, 1956) were refuted. According to one investigation (L. Morgan, 1958), the rate of psychotic, neurotic, and personality disorders among clergymen had not increased and corresponded to the proportion of the population associated with their faith group. This conclusion was supported by a series of studies (Christensen, 1959, 1961, 1963) which demonstrated that the incidence of mental illness among clergymen was the same as for the general population and that the proportion of ministers suffering from psychotic, neurotic, and personality disorders was the same as for psychiatric patients in general.⁽³⁾

(1) T.V. Moore, "Insanity of Priests and Religious: 1. The Rate of Insanity in Priests and Religious", American Ecclesiastical Review, 1936, 95, 485-498.

(2) D. Blain (1953), op.cit., p. 10.

(3) In Christensen's studies of clergymen suffering from forms of mental illness, 16 per cent were due to psychoses, 33 per cent to psychoneuroses, and 51 per cent to personality and behaviour disorders. See Appendix I: Table IA.

As far as can be judged from these studies, clergymen seem to be neither more nor less vulnerable to mental illness than anyone else. However, it may also be true, without inconsistency, that clergymen are more prone to psychiatric and psychological disorders than they are to physical complaints. For instance, in a study of hospitalised ministers, Meiburg and Young (1958) calculated that 18 per cent of the admissions were due to mental, psycho-neurotic, and personality disorders, and emotional disturbances and difficulties were reported in 35 per cent of the cases.⁽¹⁾ The majority of these manifested signs of anxiety states. So psychiatric and psychological complaints had made a significant contribution to the hospitalisation of these clergymen, most of whom were Baptist pastors. By comparison, 13.2 per cent of the admissions were due to diseases of the circulatory system and 12.5 per cent to diseases of the genito-urinary system.

It is also probable, as one would expect, that clergymen are more prone to some types of mental illness than to others. Two recent English studies, conducted by Lake (1966) and A'Brook, Hailstone and McLauchlan (1969), give no indication of the prevalence of mental illness among British clergymen but they do demonstrate the most common psychiatric problems from which they suffer.

Lake's analysis of his last one hundred clergy patients is a little difficult to follow due to the unconventional terminology and categories which he employs.⁽²⁾ However, five main types of illness or disturbance are identified, several of which could occur in any one case. Depression and depressive symptoms had been manifested by 76

(1) A.L. Meiburg and R.K. Young, "The Hospitalised Minister", Pastoral Psychology, 9 (84), 1958.

(2) F. Lake (1966), *op.cit.*, pp. 926-929.

per cent of his patients and in 39 per cent "the depression had been fully developed". Closely associated with depressive illnesses, Lake had diagnosed mildly hysterical reactions in 46 per cent of his cases and markedly hysterical characteristics in 19 per cent. Another significant group were those patients who had expressed what Lake labels as "commitment-anxiety" which he observed in 73 per cent, and these included 24 clergymen suffering from anxiety states. In 15 cases phobias to commitment, in marriage, ordination, examinations, or professional duties, had led to withdrawal, detachment and dissociation, culminating in schizoid personality reactions. Then Lake reports that 74 per cent of his patients had been aware of difficulties associated with homosexuality, either in fantasy or actuality. Of these, 37 had engaged in "some degree of homosexual involvement". So, in Dr. Lake's clinical experience, the most common psychiatric disorders suffered by clergymen have been associated with depression, hysterical behaviour, anxiety, detachment and dissociation, and homosexuality.⁽¹⁾

A'Brook and his associates report the findings of a study of 51 hospitalised clergy patients suffering from mental illness⁽²⁾ and compare these findings with an earlier study of doctors.⁽³⁾ The most common illnesses were affective psychoses and endogenous depression (35.1 per cent) and other personality disorders (10.8 per cent). Compared with doctors, clergymen were found to have a higher average

(1) See F. Lake (1966) op.cit.: the ministry and depression, pp. 286-8; hysterical behaviour, pp. 410-14; commitment anxiety and detachment, pp. 335-7; homosexuality and "andro-eroticism", pp. 1019-23.

(2) A'Brook, Hailstone and McLauchlan (1969), op.cit.,

(3) A'Brook et al (1967), "Psychiatric illness in doctors", British Journal of Psychiatry, 113, 1013, 1023, 1967.

age of breakdown (i.e. initial referral age) which occurred on average seven years later; they experienced a significantly higher frequency of organic psychoses; and they had been engaged in sexual deviations much more frequently than doctors, but drug addictions and alcoholism were considerably more common among doctors. These investigators also noted that unlike their doctor patients the clergymen had been generally co-operative and whereas a number of doctors had committed suicide none of the clergymen had attempted to do so nor had they done so subsequent to treatment.

These studies cannot be directly compared, the main difference being in the conditions of referral and treatment. Lake's sample had been private psychiatric patients, while A'Brook and his associates were concerned with hospitalised patients, which possibly explains the high proportion of psycho-neuroses diagnosed by the former and the high number of psychoses in the latter. However, two common features stand out. The first is the number of clergymen in both groups suffering from depressive illnesses. A'Brook and his co-authors could not identify a common stress factor which would account for the prevalence of depression, but they were impressed "by the frequency with which clergymen to their intense distress experience religious doubts during depressive illnesses; all patients in our sample recovered their faith when their depression had lifted".⁽¹⁾ From the various stress factors suggested to them, they single out the problem of loneliness, anomie, and isolation in the ministry for special discussion.

The second common feature is the prevalence of sexual deviations, chiefly homosexuality, paedophilia, and exhibitionism, observed in both groups. Lake attributes this to a process described as "homosexual inversion", and elsewhere he expresses the view that such "andro-

(1) A'Brook et al (1969), op.cit., p. 461.

eroticism" may be the product of intense loneliness, especially among isolated, middle-aged, and depressed clergy who then attempt to achieve social contact through "phallic symbolism".⁽¹⁾ From their observations, A'Brook et al suggest that the "ineffective father" (Anglican) and "dominant mother" (Catholic) hypotheses postulated by others may be worth exploring.⁽²⁾

However, all the evidence produced to date indicates that clergymen are generally no more prone to mental illness than the general population, and it would seem that this applies particularly to the psychoses. Among those clergymen who do suffer from mental illnesses the most commonly diagnosed disorders are those associated with depression, anxiety states, schizoid dissociation, sexual deviations, and, in older age groups, organic psychosis.

(iii) NEUROSIS AND NEUROTIC TENDENCY

Empirical findings with respect to neuroticism among groups of clergymen are inconsistent and inconclusive; showing marked differences according to the subjects and control populations studied. As noted earlier,⁽³⁾ a study of Church of Scotland students and ministers (A.V. Campbell, 1967) recorded an unusually low score for neuroticism by comparison with English male norms. But the sample was small and investigations conducted elsewhere have produced variable results.

In a theoretical discussion on the psychology of occupations Anne Roe (1956) came to a questionable conclusion.⁽⁴⁾ It was asserted

(1) F. Lake (1966), *op.cit.*, p. 1019 ff.

(2) A'Brook et al (1969), *op.cit.*, p. 460.

(3) Cf. A.V. Campbell (1967), *op.cit.*

(4) A. Roe, The Psychology of Vocations (John Wiley, N.Y. 1956). Unfortunately it was not possible to gain access to this work, and we have depended upon the abstract provided by Menges and Dittes, *op.cit.*, p. 39.

that research into the personality characteristics of those engaged in religious vocations "shows some dominance of verbal over non-verbal abilities, a generally more feminine attitude and some tendencies toward low dominance.In the religious groups there is a fairly high degree of neuroticism."⁽¹⁾ The veracity of the last observation is doubtful. It was based on only five studies, two of which (E.H. Johnson, 1943; Cockrum, 1952) do not support the conclusion.⁽²⁾

The subjects of nearly all personality studies have been students of theological colleges and seminaries using student norms as controls⁽³⁾, and the resultant profiles give an indication of pre-ministerial personality characteristics. The variability of findings is illustrated by Table 1 (over).

It is not possible to establish whether clergymen in general are more or less neurotic than other groups from these studies. In those which measure neuroticism, neurotic tendency and total adjustment the results are inconsistent. Nor is it possible to establish a definite denominational differentiation. For instance, different groups of Catholic students have recorded scores for total adjustment above and below the norm, and Protestant students have recorded equally disparate results for neuroticism. It is interesting to note, in studies of the comparative emotional stability of theological students and clergymen, that there have been no reports of clergymen being less emotionally stable than population controls.

(1) Quoted by Menges and Dittes, op.cit., p. 39.

(2) M. Argyle, Religious Behaviour (Routledge and Kegan Paul, U.K. 1961) p. 105, also disputes this conclusion and demonstrates the variability of research findings.

(3) Synopses of 22 personality studies of clergymen are presented in Appendix 1: Table IB.

TABLE I. Research Findings on Neuroticism, Total Adjustment, Emotional Stability, and other Personality Characteristics for Clergy Samples compared with Population Norms.*

Characteristics	COMPARATIVE MEASURES		
	Above	Same	Below
1. Neuroticism and Neurotic Tendency	McCarthy(1942)	G.K.Johnson(1947)	E.H.Johnson(1943) + A.V. Campbell (1967)
2. Total Adjustment	Scheuerman(1958) McDonagh(1961) Gorman(1961)	Schroeder(1956) + Campbell(1967)	McCarthy(1942) Bier(1948)
3. Emotional Stability	+Brown & Lowe (1951) Cockrum(1952)	G.K.Johnson(1952) Dodson(1957)	-
4. Depression	-	-	+Brown & Lowe(1951) Cockrum(1952) McAllister & Van der Veldt(1961)
5. Inferiority and Inadequacy	Sward(1931) McCarthy(1942)	-	Kimber(1947) Gonzales(1956)
6. Authoritarianism and Dominance	G.K.Johnson(1947)	Dodson(1957)	E.H.Johnson(1943) +D.Hamilton(1968)
7. Introversion and Passivity	Sward(1931) Laurier(1942) Schroeder(1956) Nisi(1962) +D.Hamilton(1968)	-	-
8. Social Adjustment	Kelley(1951)	Gonzales(1956)	Kimber(1947)
9. Guilt and Intro-punitive Tendency	B.Carrier(1951) G.K.Johnson(1952) Dodson(1957) +Campbell(1967)	-	-
10. Intelligence	-	-	Sadler(1929) M.A.May(1934) Laurier(1942) Kimber(1947) +D.Hamilton(1968)

*NOTE: Synopses of these studies, with details of the subjects, methods and tests used, control populations, and principal findings, may be found in Appendix I: Table IB. Complete references to the authors and publications are contained in the Bibliography. Abstracts of all but three of them (+) are presented in Menges and Dittes (1965), op.cit.

It can be seen from these 21 studies that only four characteristics and tendencies have been consistently observed in clergy sample groups irrespective of denominational affiliations. It would seem likely that they are less prone to depressive illness than other groups with whom they have been compared, even though clinical reports indicate that depression is common among those clergymen who do become sick and disturbed. It is evident that they show a marked tendency to be more introspective, introverted, passive and sensitive than others, together with a tendency toward conformity. Another striking feature to emerge, which has been the subject of much theoretical discussion, is a tendency to be more guilt-ridden particularly with respect to sexual and aggressive impulses and a tendency to be more intro-punitive, especially in the case of Protestant clergymen. One other consistent finding is that the general intelligence of theological students is usually below that of their student peers, although they frequently achieve high scores for verbal abilities.

Beyond these four general conclusions nothing can be asserted with any degree of certitude. There is no evidence that clergymen are unusually neurotic or emotionally maladjusted as a group. At the same time, it is apparent that psychoneuroses such as depressive reactions, anxiety states, and emotional dissociation do make a significant contribution to the illnesses and difficulties experienced by clergymen.

(iv) PERSONALITY DISORDERS

As with the psychoses and neuroses, there is no evidence of personality disorders and behaviour problems being more common among clergymen than is true of the general population or other professional

groups. It has been reported that personality disorders are involved in about half the cases of clergymen seeking psychiatric treatment (Christensen, 1963 (b); Lake, 1966; A'Brook et al, 1969), but this is evidently no more frequent than for the proportion of the population receiving such treatment.

Few details have ever been presented of the specific kinds of personality disorders most commonly experienced by clergy groups. The only exception are problems associated with sexual difficulties and deviations (Hudson, 1951; Bowes, 1963; Bowers, 1963; Lake, 1966; A'Brook et al, 1969). Sexual deviations are certainly much more common among English clergymen than among doctors (A'Brook et al, 1969), but this may be an isolated case. These disorders may be unusually common among clergymen, but the details are imprecise. By contrast, alcoholism and other drug addictions, for instance, are rarely mentioned and are not unusually prevalent (T.V. Moore, 1936; McAllister and Van der Veldt, 1961; A'Brook et al, 1969).

It can be seen, therefore, that the burden of empirical evidence suggests that clergymen generally experience a reasonable degree of physical, mental and emotional health. In fact, their record of physical health and longevity has been remarkable, while their experience of mental, emotional, and personality disorders has not been significantly better or worse than one would expect by comparison with other professions or the male population. Furthermore, there has been no evidence of a marked decline in the health of clergymen, at least, not prior to 1960. However, against this background, six most commonly observed difficulties keep recurring in reports of empirical and clinical research and are frequently examined in theoretical discussions.

(1) Most groups of clergymen, with some exceptions, have experienced high rates of death from coronary heart disease. This phenomenon has not been the subject of detailed research to date and remains a mystery.

(2) Guilt, especially with respect to sexual and hostile impulses, expressing itself in excessively critical self-appraisal, sensitivity to failure, suppression and possibly repression of undesirable impulses, and in a tendency to be intropunitive and self-punishing, is apparently a major area of difficulty for clergymen. Without doubt, the relationship between guilt, sexuality, aggression, repression, and self-punishment is the most discussed theme in considerations of health of clergymen. Some writers have considered the complex and dynamic interaction between guilt, repression, and intro-punitiveness to be a primary cause, if not the root cause, of most of the difficulties experienced by clergymen (viz. R. May, 1939; Dodson, 1957; Southard, 1958; Hudson, 1951; G. Booth, 1958; Wheelis, 1958; and others). For instance, in discussing the potential consequences of the minister's struggles with sexual and hostile emotions, R.L. Hudson (1951) warned that the minister is inclined

"to repress his hostility and turns upon himself with the punishment of insomnia, or a stomach ulcer, or a skin rash. His hostility may even become displaced and he is "overbearing" to his family, or becomes unmotivated (lazy, his parishioners will call it) in his pastoral duties, or he may quietly seek a change to another pastorate."⁽¹⁾

Whatever the causes and the consequences, it seems that guilt and

(1) R.L. Hudson, "The Emotions of the Minister", Pastoral Psychology 1951, 2 (14), p. 35.

self-punishment possibly play an important part in the health of clergymen.

(3) Clergymen frequently experience difficulties in interpersonal relationships, in satisfying the need for intimacy and in establishing secure personal relationships. Their relationships are not infrequently characterised by passivity, withdrawal, detachment, and in a proportion of cases by schizoid reactions. There is disagreement, however, as to whether such interpersonal problems arise out of personality factors or whether they are the product of social isolation due to their professional status.

(4) Closely allied to problems in the interpersonal dimension of personal life and with the need for intimacy, difficulties and disorders associated with psychosexual development and sexual deviations are relatively common among clergymen.

(5) Compulsive-obsessive behaviour manifested in perfectionism, scrupulosity, fears of failure, and a compulsive drive to over-work has been frequently observed in groups of clergymen. Once again the question is whether such behaviour is symptomatic of underlying personality problems or whether it is the product of occupational pressures.

(6) Depressive illnesses and anxiety states are reportedly common among clergymen who become sick and disturbed. Depression and depressive symptoms, lethargy, inactivity, loss of vocational motivation, lack of concentration and co-ordination, withdrawal, are particularly prevalent. Numerous personality and occupational factors have been put forward to explain the frequency of depressive illness in clergy groups but no single factor stands out.

This then is the general picture to emerge from a survey of research conducted elsewhere. However, whether this "typical" pattern

of health and illness in groups of clergymen applies to the experience of Church of Scotland ministers remains to be seen. Allowance must be made for the distinctive conditions, denominational traditions and practices, system of Church government and organisation, theological beliefs and attitudes, socio-cultural environment, to which they are subject. It is the primary purpose of this research project to establish the facts of their experience in a systematic manner.

HYPOTHETICAL CONSIDERATIONS

Various theories and hypotheses have been put forward to account for the typical illnesses and complaints observed in groups of clergymen. Possible hypotheses tend to fall into three main groups: those in which these illnesses are primarily attributed to either occupational or psychological or vocational factors. However, in formulating hypotheses it is also necessary to consider the possible interactions between occupation, personality, and vocation as dimensions of the individual minister's personal experience. They are inextricably bound up together and impinge on each other in the person's living experience. Hence, it is not possible to examine the effects of any one of these dimensions in strict isolation from the others.

Most speculation arising from investigations of the health of clergymen concerns the relative influence of and the relationship between the minister's personality and the nature of his occupation. The basic problem is whether occupational stresses and conflicts experienced by clergymen are symptomatic manifestations of unresolved personality problems or whether they are the product of difficulties inherent in the nature and conditions of the ministry. For instance, we are forced to consider whether problems associated with excessive guilt, a tendency to be intro-punitive, emotional withdrawal and social

isolation, depression and anxiety are the outcome of unresolved intrapersonal conflicts characteristic of a pre-ministerial personality type or whether they are produced by occupational conditions and stresses to which the minister is subject. Another possibility is that they may be effected by a reciprocal process of interaction between personality and occupational factors.

(1) OCCUPATIONAL FACTORS. It is beyond dispute that the well-being of individuals, groups, and communities is contingent upon the complex matrix of environmental conditions in which they have their existence. As F.A.E. Crew (1951) asserted:

".....the possibility of remaining healthy is decided not so much by the individual's own constitutional aptitude as by the content, conditions and circumstances of the social and physical environment in which he has his being".⁽¹⁾

Such diverse environmental factors as climate, nutrition, housing standards of hygiene and sanitation, environmental pollution or preservation, population density, level of industrialisation, medical knowledge and resources, socio-economic and cultural conditions make an impact on the health of individuals and communities.

Occupation is another environmental factor, or more correctly, a configuration of factors, which has a significant influence on health, and "It is established", to quote Professor Crew again, "that the conditions associated with work affect the individual's health."⁽²⁾ The relationship between occupation and health is amply demonstrated by the occupational variations evident in mortality studies. But, while this relationship is readily demonstrable in terms of effects,

(1) F.A.E. Crew, op.cit., p. ix.

(2) Ibid., p. 49.

the casual factors and processes involved are elusive because of the diversity and multiplicity of occupational variables which could influence the individual's health. Some variables are intrinsic to the conditions of an occupation: type of work, forms of physical and mental activity, hours of work, income and socio-economic status, sources of stress, occupational mobility, provision for leisure, and so on. But an occupation also has products which materially affect the whole life-style of those engaged in it, and could influence standards of living, housing and residential locale, diet, family size, social customs and activities, and personal interests. Occupation may, therefore, have far-reaching effects on the individual's entire pattern of living.

Despite the intricacies involved, it is quite clear that occupation affects the health of individuals and groups. In some instances the relationship between occupation and health appears to be self-explanatory, as, for example, the prevalence of silicosis among quarry workers or the frequency of accidental death and disablement among transport workers. In other cases the reasons for the relationship are obscure, as is true of the high incidence of coronary disease within professional and executive occupations and research has failed to isolate any specific occupational factor to account for this phenomenon. It is not even certain that coronary disease can be appropriately described as an occupational disease.

Peculiar health hazards are inherent in any occupation, and both beneficial and detrimental factors are probably woven together in a distinctive pattern in the conditions of each occupation. The ministry is no exception. The problem is to identify the peculiar threats to

personal health to which ministers are exposed in fulfilling their vocation.⁽¹⁾

According to one hypothesis, which we could call the "overwork" hypothesis, the typical complaints suffered by clergymen are attributable to overwork which stems from increasing demands made on ministers and from the pressure of carrying out multiple functions. Under these conditions ministers lack opportunities for relaxation, recreation, and personal social life, and the pressure of work without respite eventually takes its toll on their health. This thesis was implicit in Shrader's (1956) contention that more clergymen were "breaking down" due to an increase in the expectations imposed on them by parishioners.⁽²⁾ Similarly, the petition to the General Assembly of the Church of Scotland in 1969 claimed that the health of its ministers had declined significantly because of a marked increase in the "mental effort and pace" required in the ministry.⁽³⁾ However, this hypothesis has gained little support and has been discounted by several investigators (Oates, 1958; Morgan, 1958; Southard, 1958; Meiburg and Young, 1958) all of whom consider that excessive overwork is in fact symptomatic of underlying personality problems.

A more widely-held view could be described as the "mental and emotional stress" hypothesis, in which clergymen's experiences of depression, anxiety, compulsive-obsessive behaviour, social isolation, and even some functional disorders, such as gastric ulcers, hypertension,

(1) D. Blain (1953), op.cit., and W. Oates (1958), op.cit., both devote their attention to peculiar health hazards of the ministry, with the emphasis on psychological and emotional threats to health.

(2) W. Shrader (1956), op.cit.

(3) Referred to in detail, q.v. p. 79-81.

chronic digestive complaints, or coronary disease, are understood as occupational diseases precipitated by stresses inherent in the conditions of the ministry. This broadly formulated occupational stress hypothesis has many advocates and research has indicated that clergymen often experience relatively intense forms of mental and emotional tension. However, the sources of such stress are potentially limitless, and due to the intangible quality of psychological stress it is difficult to verify this hypothesis. The problem of specificity, that is, of identifying and delineating particular forms of stress to which ministers may be exposed, presents a fundamental difficulty in achieving precision and reliability.

The potentially harmful effects of having to live up to demanding but often non-explicit expectations imposed on clergymen by traditional Christian teaching, denominational requirements, congregational necessities, parishioners' demands, and cultural traditions, is frequently referred to as a major threat to the health of ministers. They are required, so it is argued, to sustain an idealistic and unreasonable "image" of godliness, holiness, self-discipline and austerity as professional lovers of people which is impossible to attain or sustain. One minister has been reported as describing the minister, as a cultural-religious representative, in these terms:

"The best way to describe this cultural-religious representative is to say that he is a paid gigolo. He is a paid lover of people, and by so doing he clouds their calling to love one another."⁽¹⁾

The effect of attempting to match up to these expectations and the 'image' of the ministry as a moral and spiritual elite is to severely circumscribe the minister's personal life and to subject him to

(1) The United Presbyterian Church in the United States (ed. R.C. Johnson), The Church and its Changing Ministry (1961), p. 4.

perpetual strain. In face of these expectations the minister may become passive and conformist, his freedom in expressing emotions stifled, and his sexual and aggressive impulses diverted by sublimation and suppression, if not completely repressed; the minister's capacity for forming intimate relationships may be inhibited and his social relationships and recreational activities restricted; he may be driven to engage in compulsive overwork; and he may experience guilt, depression, anxiety, and possibly functional disorders in consequence of what he perceives to be personal failure or inadequacy.

Expectations associated with the image of the ministry, however, are not the only possible source of stress for clergymen. The minister's professional responsibilities embrace diverse functions and the problem of establishing an acceptable system of priorities and a balanced use of the time available could produce tension for the clergyman. In addition, the minister's pastoral duties may involve him in circumstances which demand a high degree of emotional investment and tension. In these situations, the minister may have difficulty in handling his own emotional responses and in achieving a balance between participation and observation, without succumbing to the danger of over-identification and without over-protecting himself by emotional detachment. Achieving such a balance may be unusually difficult especially when all his principles require that he should be concerned and compassionate. The material sacrifice and austerity required of the minister and his family, by comparison with other professions, could be another source of tension and could foster resentment, anxiety and frustration. This may be especially acute if the minister feels, possibly with some justification, that he should maintain a standard of living which befits his professional status and if he feels that he is unable to do justice to his family's needs..

Occupational stress may have profound effects on the minister's well-being and may put his health in jeopardy. Nevertheless, an important prior question which must be considered is whether such stress is real or imagined, whether it is intrinsic to the nature of the ministry or whether it is in some sense self-imposed as the product of the personality problems of ministers themselves. Most of these stresses can be related to the quality of apartness, in terms of moral rectitude, spiritual excellence, self-discipline and austerity, which appears to be implicit in the common image of the ministry. But the question emerges as to whether the extent to which the minister is set apart is a necessary feature of the ministry or whether it is a reflection of the minister's emotional needs, unconscious motives, and inner conflicts.

According to another view, to which many researchers subscribe, role conflict and professional identity confusion may contribute to the typical illnesses of clergymen. The hypothetical relationship between role conflict and the health of clergymen is stated by W. Oates (1958):

"Another opinion of mine is that ministers today are having more and more difficulty in their personal life because we are trying to apply ideals for the ministry which we received from a distinctly rural community to the radically altered demands of an urban situation."⁽¹⁾

In the contemporary conditions of rapid socio-cultural change, the traditional role and functions of parish ministers have been the subject of extensive sociological investigation⁽²⁾ and intensive theological

(1) W. Oates (1958(b)), "The Mental Health of Ministers", Pastoral Psychology, 1958, 9 (84), p. 7.

(2) This is clearly demonstrated in the studies listed by Menges and Dittes (1965), op.cit.: 22 investigations of the parish ministers' "Role", 23 studies of "Role Conflicts", 42 of "Role Expectations", and 44 of ministerial "Functions" are reported.

re-evaluation.⁽¹⁾ The Churches in Western societies have been confronted with the need to reformulate the concept of the ministry in order to adjust to the structures of pluralistic-industrial-urban societies. Some writers, like W. Oates, consider that confusion surrounding the professional role or identity of the minister has given rise to occupational conflicts which threaten the health of clergymen and which furthermore, may have caused their health as a group to deteriorate in the post-war era.

In a notable series of studies, C.W. Blizzard has highlighted the extent of conflicts between ministers, Church administrators, parishioners, and social expectations over the essential purpose of the ministry within the context of the Church and the wider community.⁽²⁾ These studies expose the lack of a precisely defined "master role" or integrating identity for the ministry which is appropriate to the conditions of contemporary urban societies and demonstrate the diversity of the role expectations imposed on clergymen from many directions. In the context of conflicting role expectations, Blizzard says, "The urban minister faces the problem of emotional maturity and the desire for self-understanding".⁽³⁾ The fundamental dilemma is whether the essential

(1) A stimulating attempt to reformulate the concept of the ministry was presented by H.R. Niebuhr, together with his associates, in "The Purpose of the Church and its Ministry" (Harper and Brothers, N.Y. 1956), which served to provoke further discussion. A forthright examination of the ministry was sponsored by the United Presbyterian Church in the U.S.A. in a study programme eventually published as "The Church and its Changing Ministry" (1961), op.cit. Almost innumerable publications have contributed to the continuing theological inquiry into the nature of the ministry in the last decade.

(2) The relevant studies by Blizzard are listed in the Bibliography.

(3) C.W. Blizzard (1956)(a), "Role Conflicts of the Urban Minister", The City Church, 1956, 7 (4).

nature of the ministry is ideological, functional, or inspirational, as to whether the parish minister's primary role is as a preacher and evangelist, or as a pastoral director, or as an exemplary representative of Christian faith and morality.⁽¹⁾

In the absence of a generally accepted role the individual minister may be the victim of potentially harmful conflicts, as is borne out in a study by L.L. Falk (1963).⁽²⁾ By investigating ministers' responses to role conflict, it was shown that when there was marked disagreement between parishioners then ministers tended to repudiate unacceptable expectations and to assert their personal role definition. But when parishioners consensually disagreed with a minister then he tended to become depressed rather than reacting in an overt manner. However, as in the case of occupational stress, the minister's personality may be an important factor in determining his response to role expectations and to external pressures of this kind.

Professional identity confusion surrounding the essential purpose of the ministry may have subsidiary products in other forms of conflict. Lacking a focal thrust for his ministry, the minister may experience conflict over the relative importance of his preaching, teaching, pastoral, priestly, and administrative functions. Tension between his functional priorities may be both theoretical and practical, and, without clear standards by which to evaluate success and effectiveness and without a clear sense of direction, the clergyman may engage in a futile and frustrating attempt to satisfy diverse and possibly non-

(1) For example see the discussions provided by H.R. Niebuhr (1956), *op.cit.*, p. 48 ff. and C.W. Blizzard (1956(b)), "The Minister's Dilemma", Christian Century, 1956, 73.

(2) L.L. Falk, "The Minister's Response to Role Conflict", "Discourse", 1963, 6, 216-218.

essential demands. As he becomes occupied in numerous activities, apparently at random, and as he progressively loses control over the use of time, the clergyman may experience acute conflict between his public and private lives, between his professional and personal responsibilities. In fact, several investigators have focussed attention on the conflict between the ministers' professional obligations and their personal wishes and duties as possibly a critical source of tension.

In considering the hypothetical possibilities associated with the nature of the ministry as an occupation it is not necessary to adopt an exclusivist position. It is possible, indeed probable, that each of these factors and processes, the physical and mental conditions of the ministry, the kinds of stress to which ministers are exposed, and the conflicts which arise in the conduct of the ministry, makes some contribution to the health and illness of clergymen. But the question still remains as to whether or not these occupational conditions precipitate personality problems and conflicts or whether personality problems create occupational stresses and conflicts, and as to whether occupational conditions and personality characteristics have a complementary effect on each other.

(2) PERSONALITY FACTORS. There is a distinct possibility that the vulnerability of clergymen to guilt, intro-punitiveness, passivity, social isolation, depression and anxiety, and to some functional disorders, is as much due to typical personality problems as it is to occupational factors. It has been argued that men enter the ministry with unresolved intra-personal conflicts, frequently over difficulties associated with identity, authority, and intimacy, and that these conflicts are aggravated in the conditions of the ministry, eventually

precipitating the disorders to which clergymen are most prone. Moreover, it has been argued that an unconscious desire to resolve such conflicts may be a significant factor in the choice of the ministry as a vocation and that the ministry may be perceived as a means of compensating for or escaping from frustrations of childhood and adolescence. But, ironically, instead of providing the hoped for resolution, these conflicts are often intensified by parish experience. In this view a particular personality type tends to be attracted to the ministry in an unconscious pursuit of satisfaction for unfulfilled needs.

The basic issues involved in the personality hypothesis are illustrated by clergymen's problems associated with overwork, lack of opportunities for relaxation, and inhibited social relationships. Most investigators reject the view that these features of the minister's life are imposed by external pressures and expectations inherent in the nature of the ministry. Instead, it is claimed, clergymen are often the victims of their own inner-compulsions, conflicts, and needs. They are frequently driven by infantile fancies of omnipotence and seduction, possibly arising out of deeply-rooted fears of inferiority, unworthiness, and rejection, which are manifested in excessive devotion to duty, idealistic perfectionism, subjection to the tyranny of shoulds and oughts, inability to tolerate opposition or competition, and in compulsive striving for success, prestige, approval and admiration. If there is any empirical foundation for this contention, then one would expect such striving to be self-punishing and self-defeating in its effects. This hypothesis is implicit in W. Oates' (1958) opinion that clergymen "break because of their inability to share, delegate, and correlate authority with other people, not because of overwork".⁽¹⁾

(1) W. Oates (1958(a)), op.cit., p. 24.

The personality hypothesis revolves around a configuration of characteristics, symptoms, and processes often observed in the personalities of clergymen. At the risk of over-simplification, this configuration could be described as a "guilt-neurosis syndrome".

Unquestionably, the most discussed feature of the experience of clergymen is the acute guilt which seems to accompany sexual and aggressive impulses and the tendencies to be intro-punitive, to severely control emotional expressions by self-discipline, and to suppress or repress these supposedly undesirable impulses, (May, 1939; Carrier, 1951; Hudson, 1951; Johnson, 1952; Dodson, 1957; Oates, 1958; Shroeder, 1958; Wheelis, 1958; Bowes, 1963; Lake, 1966). The theme of exaggerated and misplaced guilt and its potentially damaging effects on personal health keeps recurring in technical and theoretical discussions on the health of clergymen. It is derived from an extended deductive process, coordinated with theories of personality development, and therefore any attempt at summarisation can only do less than justice to the intricacies involved.⁽¹⁾

The "guilt-neurosis syndrome" probably has its origins, according to this line of reasoning, in the clergyman's early relationships, especially with parents and other significant figures in early childhood. It is likely that parental expectations tended to be inexplicit but implied the attainment of intangible and idealistic standards of achievement and conduct, and parental disapproval or disappointment at any failure to reach these ideal goals acted as a form of psychological punishment. These parental expectations and disapproval then became

(1) In view of its undoubted importance in considering the health of clergymen, this hypothesis will be given more detailed attention in Part V: Conclusions.

introjected in the development of a severe and self-punishing conscience or super-ego which exercised a curbing effect on the child's instinctive impulses and desires. Particular emphasis was possibly placed upon the need to restrain sexual and hostile impulses in the child's perception of parental attitudes and demands. As the result of the development of a "puritan conscience" by this kind of process, the foundations had been laid in the child's personality of a perpetual conflict between impulse and control, desire and restraint, or between the id and an oppressive super-ego in terms of classical psychoanalytic theory.

The clergyman's conflicts between the poles of intimacy and isolation, individuality and dependence, autonomy and authority, and the passive-aggressive polarity also originate in the ambivalent feelings fostered in early relationships, particularly with parents. The "ineffectual father-dominant mother" hypothesis has relevance. The relationship with his father has been emotionally shallow and distant; but the child has, nevertheless, perceived his father as a remote and unapproachable authority whom he regarded with a measure of respect and admiration. Hence, his ambivalent feelings evident on hand in a desire to compete with and rebel against the authority represented by his father, and on the other in a wish to achieve a closer relationship by obtaining his father's approval and admiration. By contrast, the relationship with his mother has been equally affect-laden, characterised by her dominance and possessiveness and by his passivity and dependence. In consequence, the clergyman's developing personality has been shaped by the conflicting and ambivalent desires to gain freedom from maternal domination and smothering but to achieve independence and individuality without a loss of maternal affection. Out of the ambivalent feelings

associated with these Oedipal constellations in the formative years of personality development, the clergyman acquires not only an intro-punitive conscience but becomes the victim of acute intrapersonal conflicts associated with intimacy, authority, independence, and personal identity.

The residual effects of these intrapersonal conflicts are then "transferred" (Cf. S. Freud) or carried-over as "parataxic distortion" (Cf. H.S. Sullivan) and affect all the individual's subsequent interpersonal transactions and his decision-making facility. The images of a remote, unapproachable father and a possessive, dominant mother remain with him as unconscious and "imaginary" third persons,⁽¹⁾ and the need to fulfill or excel the "expectations" of these ghost-like figures from the past infects all of his relationships and conduct.

Infantile needs, frustrations, and conflicts of this kind, according to some theorists, may be a potent source of unconscious motivation in the decision to enter the ministry.⁽²⁾ To the adolescent, a religious vocation appears to offer a means of compensating for or of escaping from these tensions and to provide a solution to his personal identity-crisis. The ministry seems to offer some prospect of relief from guilt-feelings and at the same time seems to bolster the individual's

- (1) The concept of continued parental influence as "imaginary" third persons is a fundamental aspect of the concept of parataxic distortion postulated by H.S. Sullivan (1954), *op.cit.*, p. 230 ff.; but it should be noted that this kind of unconscious influence need not be confined to parents, it may be exerted by other significant figures in infancy and childhood.
- (2) The contribution of infantile motivations in the constellation of factors leading to a vocational decision to enter the ministry is discussed by A. Wheelis, *"The Quest for Identity"* (N.Y. 1958), p. 207-210; C.A. Wise, *"The Call to the Ministry"*, *Pastoral Psychology*, 1958, 9 (89); Gotthard Booth, *"Unconscious Motivation in the Choice of the Ministry"*, *Pastoral Psychology*, 1958, 9 (89).

conscience as a curb on unacceptable impulses; it seems to promise the possibility of satisfaction of a need for intimacy through a variety of personal relationships but within a safe framework in which affectionate needs are unlikely to become uncontrollable; it conveys authority, status, and public respect together with autonomy, independence, and freedom from competition; it affords the possibility of attaining individuality without necessitating aggressive rebellion and the loss of approval and admiration.

It is ironical, however, that far from being allayed, basic intrapersonal conflicts and frustrations tend to be revived and reinforced within the actual conditions of the ministry. Guilt feelings are not relieved, as even greater pressures and expectations are imposed on the minister; and in face of failure and inadequacy, guilt is magnified, involuted aggression is intensified, emotions are inhibited or repressed, and the outcome can only be greater passivity or excessive rebellion. Instead of satisfactory intimacy within a secure framework, the minister becomes further isolated by his professional status with the effect of producing either an even more compulsive quest for approval and affection or a reaction of emotional detachment. Instead of receiving authority with freedom from competition, the minister is confronted by many external authorities and vigorous competitors or possibly finds himself in possession of more authority than he can handle, and the effects may be evident in greater authoritarianism and dogmatism or in progressive withdrawal and isolation. Instead of achieving personal identity and individuality, the minister is absorbed by a ministerial role in which he is expected to preserve a traditional image or professional identity and is caught in yet another passive-aggressive conflict. In these processes, personality characteristics and

occupational conditions play on one another in a subtle and dynamic interaction in the individual's over-all experience; and it is out of this process, so it is argued, that the disorders and illnesses to which clergymen are peculiarly prone eventually emerge.

The speculation surrounding the relationship between clergymen's personalities, vocation, occupation, and their health is of obvious importance and cannot be lightly discarded. Three inter-related strands can be identified in the argument leading up to the broad personality hypothesis. The first concerns the link between the role of guilt in the clergyman's personality and his health, which implies a guilt-neurosis hypothesis. A personal identity-crisis hypothesis is implied in the second strand which postulates a bond between the clergyman's difficulty in establishing a clear sense of his individual identity and his health. Then there is the third component in which experiences of guilt and of identity diffusion are related to the clergyman's vocational decision, which introduces the possibility that the minister's religious vocation and beliefs may have some influence on his well-being.

(3) VOCATIONAL FACTORS. Most attention has been devoted to the influence of occupational conditions and personality characteristics on the health of clergymen. However, a third group of hypotheses are those in which a possible relationship between religious vocation, beliefs, and practices, and personal health is postulated. These pose the question as to whether the clergyman's religious convictions and behaviour have healthy or unhealthy effects on his physical, mental, and emotional well-being. Investigators in this field have probably been reluctant to explore the relationship between faith and health in the experience of clergymen because of the well-nigh insoluble theoretical and methodological problems involved, although some authors have made

cautious reference to the beneficial resources which may be available to the clergyman through his faith.

The relationship between religious belief and health has had a prominent place in the psychological study of religious behaviour and has proven to be a contentious issue, attracting the attention of many notable psychologists (viz. W. James, Freud, Thouless, Boissen, Frankl, Fromm, R. May, G.W. Allport and many others). This is not surprising for, as Gordon Allport observes, "a psychology that impedes understanding of the religious potentialities of man scarcely deserves to be called a logos of the human psyche at all."⁽¹⁾ There can be no doubting the fact that psychological inquiry enhances our understanding of the empirical causes, conditions, and processes within the person by which religious belief is, at least in part, fostered. At the same time, it must be acknowledged and reasserted that, as a science, psychology is unable to either prove or disprove the essential truth of religious belief itself. However, both abstract and empirical inquiries⁽²⁾ into the relationship between faith and health have been provocative and there is every reason to approach this subject with caution. Nevertheless, in view of the predominant roles played by religious faith and a particular religious vocation in the minister's life, it is an issue which cannot be easily dismissed with reference to the health of clergymen.

The most contentious issue to emerge from the psychological study of religion, which has relevance here, concerns the essential healthi-

(1) G.W. Allport (1955), Becoming (Yale Univ. Press, U.S.A., 1966), p. 98.

(2) M. Argyle (1958) Religious Behaviour (Routledge & Kegan Paul, 1961), p. 101 ff., considers the relevant evidence with respect to the relationship between religion and mental disorder. Orlo Strunk, Reading in Psychology of Religion (Abingdon, 1959) provides a helpful collection of readings on the nature of belief and on the relationship between belief and psychopathology.

ness or unhealthiness of religious belief. Some psychologists have subscribed to the belief that religious faith per se constitutes a form of maladjustment and is essentially pathological. The most outstanding advocate of this "faith-neurosis" hypothesis was Sigmund Freud for whom religious faith manifested a universal obsessional neurosis:

"One might assume that in its development through the ages mankind experiences conditions that are analogous to neuroses.....repression-like processes. Thus religion would be the universal obsessional neurosis of humanity..... originated in Oedipus complex, the relation to the father."⁽¹⁾

Freud's opinion obviously depends upon prior assumptions about the truth of faith and about human nature, history, and destiny, and not surprisingly has been the subject of vigorous debate.⁽²⁾ Nevertheless, Freud recognised the obvious Oedipal implications of religious belief: dependence on a divine father, love-hate ambivalence toward that father, guilt arising out of ambivalence, and the need to atone for the guilt. By applying the concept of an Oedipal Complex as a universal principle, religious faith can then be seen to be an illusion created by mankind as an emotional crutch and soporific to provide comfort and support in face of helplessness. Faith is then stripped of transcendental or ultimate significance and reduced to the proportions of a neurotic defense mechanism.⁽³⁾

(1) S. Freud, The Future of an Illusion (Hogarth Press, 1928).

(2) The debate had its beginnings in the correspondence between Freud and Oskar Pfister, the Swiss pastor: H. Meng and E.L. Freud (ed.), Psychoanalysis and Faith. The Letters of Sigmund Freud and Oskar Pfister (Hogarth Press, 1963), but has gone on from there with many protagonists on both sides entering into the discussion.

(3) It will be obvious to those acquainted with Freud's work that this is a facile summation which does less than justice to the variety and subtlety of his insights into the nature of religious belief. It

It must be acknowledged that Freud rendered a valuable service in exposing the neurotic pathology of those forms of religion characterised by emotional dependence and immaturity, lack of autonomy, misplaced and unnecessary guilt, suppression and repression, in which the gods are merely projections of human fears, insecurity and desires. He is not alone in his critique of unhealthy forms of religion.⁽¹⁾ But to present this criticism as though it were a universal absolute, which supposes that all forms of religious belief contain no ultimate truth and are essentially neurotic, is questionable.

Similarly, Leuba argued from the prior assumption that the ultimate truth of faith has no validity or substance and maintained that faith

is beyond our scope to examine Freud's theories in depth in this context. But it should be noted that his doctrine of faith as a universal neurosis was only one aspect of his published thinking about religious belief and its significance. Over a period of twenty years, from Totem and Taboo in 1919 to Moses and Monotheism in 1939, Freud's speculation underwent a great deal of modification and qualification, and it would seem from the apparent inconsistencies that he came to no absolute conclusions on the subject. N.O. Brown, Life against Death (Vintage 1959), p. 12 f. discusses the element of paradox and ambiguity present in Freud's theories of religion.

- (1) For example, T.S. Szasz, in The Myth of Mental Illness (Secker and Warburg, 1962), p. 183 ff., launches a scathing attack on common attitudes in Judaism and Christianity which foster helplessness, self-denigration, disability and illness, and which restrict the development of self-determination, self-reliance, and responsibility by perpetuating the "game played in childhood" based on rules of the helpless child and the helpful parent. It is a critique which cannot be lightly passed off as being inconsequential. However, the attack on immature and neurotic forms of religious beliefs has not been confined to psychology and psychiatry. Tillich has been equally critical of the kind of religious faith in which "God appears as the invincible tyrant, the being in contrast with whom all other things are without freedom and subjectivity. He is equated with the recent tyrants who, with the help of terror, try to transform everything into a mere object, a thing among things, a cog in the machine they control.....This is the God Nietzsche said had to be killed because nobody can tolerate being made into a mere object of absolute knowledge and absolute control." (The Courage to Be, 1952, p. 179).

can only be understood as an emotion. Faith is purely the product, in his view, of an "inner emotional warfare waged in the interest of a higher, and so far unattainable, mode of life".⁽¹⁾ Depression and dissatisfaction are invariably present in "the incubation stage of faith" and are replaced by a satisfactory state which varies "from calm satisfaction to exuberant joy".⁽²⁾ Despite the relief of depression and frustration provided by faith, Leuba considered it to be an unrealistic and illusory solution based on self-deception and, therefore, essentially neurotic. However, as in the case of Freud, Leuba's views are not without ambiguity, for he also noted that this emotional state called faith was usually accompanied "by a steadiness and efficiency of purpose in striking contrast with the preceding impotency of the will."⁽³⁾ So presumably this illusory state could produce beneficent effects.

Although William James did not regard faith as essentially neurotic, he did suggest that "the neurotic temperament" may be a necessary precondition of the development of faith. He observed the presence of melancholy in "every complete religious evolution" and went on to suggest:

"If there was such a thing as inspiration from a higher realm, it might well be that the neurotic temperament would furnish the chief condition of the requisite receptivity".⁽⁴⁾

With reference to the health of any group of clergymen, the implications of the contention that faith is in itself a form of mental

(1) J.H. Leuba "Emotions of Faith", in O. Strunk, op.cit., p. 193 ff.

(2) Ibid., p. 194.

(3) Ibid.

(4) W. James, "The Varieties of Religious Experience" (Longmans, Green & Co. 1909) p.

or emotional maladjustment are inescapable. Then clergymen, as men of faith who devote their lives to its promotion, are ipso facto more or less maladjusted and neurotic. However, this contention has been challenged on both empirical and logical grounds.

It is not our task to become yet another participant in the debate over the essential healthiness or unhealthiness of religious belief, but some observations are pertinent. The argument behind the faith neurosis hypothesis depends upon the assumption that religious faith has no substance in reality and is devoid of transcendental significance.⁽¹⁾ Some psychologists have supposed that the presence of physical or psychological processes in religious experience invalidates the ultimate truth of faith. Therefore, faith is a purely natural phenomenon which can be completely explained in scientific terms without recourse to any transcendental phenomena or agent. If this is so, then faith can only be understood either as a relatively harmless but meaningless product of physiochemical processes or of conditioned learning or as an illusion created by human self-deception and wishful-thinking as a neurotic solution to unconscious needs. But such a deduction has no scientific validity, and makes neither scientific nor theological sense; as Argyle pointedly asks, "But did anyone seriously consider that religious belief and experiences were a series of random events, unrelated to any natural causes?"⁽²⁾ Indeed,

(1) In fact, in "The Future of an Illusion", op.cit., p. 57, Freud explicitly stated: "It does not lie within the scope of this inquiry to estimate the value of religious doctrines as truth". But as R.S. Lee observes: "In spite of his disclaimer cited above, Freud seems to assert, and many of his followers definitely assert, that his arguments disprove religion". Freud and Christianity (Pelican, 1967), p. 15.

(2) M. Argyle, op.cit., p. 2.

it would be quite astonishing if physical, psychological, and social factors did not contribute to the development of religious belief. The notion of unaided divine action presupposes a God who interferes with and disrupts the conditions of human existence in order to achieve his purposes, which is unacceptable to both scientific knowledge and informed theological inquiry. Tillich argues that this concept "is distorted because it means that God has to destroy his creation in order to produce his salvation", and, furthermore, it is "Demonic, because God is then split in himself and is then unable to express himself through his creative power".⁽¹⁾

Moreover, it is evident that the psychologist is not stating an empirical, scientific fact in concluding that religious faith has no substance and is devoid of ultimate truth. Such an assertion can only be made as another expression of faith or belief, itself based upon abstract, a priori assumptions about human nature and existence reflecting a naturalistic, deterministic, and materialistic 'world-view' or on the belief that particular scientific truths have universal significance and are essential to the whole of reality. Tillich has persistently emphasised the importance of distinguishing between scientific truth and the truth of faith, between verifiable empirical facts and assertions of faith, as belonging to different realms of meaning. Referring to this differentiation, he comments:

"It is.....not difficult in the statements of depth psychology to distinguish the more or less verified observations and hypotheses from assertions about man's nature and destiny which are clearly expressions of faith.....There is no reason to deny

(1) P. Tillich (1965), Ultimate Concern (S.C.M. 1965), p. 159, where he discusses the nature of miracles and dismisses the concept of supernatural intervention in the created order as being demonic.

a scholar who deals with man and his predicament the right to introduce elements of faith. But if he attacks other forms of faith in the name of scientific psychology, as Freud and many of his followers do, he is confusing dimensions".⁽¹⁾

This is not to claim that religious belief and behaviour is or even should be inaccessible to scientific investigation. The psychologist may illuminate the empirical causes, conditions, and processes by which religious belief is fostered. But beyond that, in applying himself to the ultimate validity of religious faith, the psychologist moves from the realm of scientific truth into that of essential truth. Again, this is not to suggest that the psychologist should refrain from expressions of personal faith. Without a framework of meaning, that is without a faith, his observations would be inconsequential. However, it does require that his expressions of faith should not be presented in the guise of being assertions of scientific truth bearing the full weight of scientific authority. It means, moreover, that scientific truth and the truth of faith cannot be employed to verify or invalidate one another and the one cannot claim primacy over the other. They belong to different categories of meaning.

These observations raise much larger conceptual issues concerning the nature of man and his existence, the significance of natural and supernatural phenomena, the relationship between empirical and essential truth, and the essential relationship between faith and health. At this point we are chiefly concerned with the notion that faith is a neurotic defence-mechanism as it bears on the health of clergymen. This is only one perspective in an extensive debate.

(1) P. Tillich (1957(a)), The Dynamics of Faith (Allen and Unwin, 1957), p. 84-5.

In response to the faith-neurosis concept, some psychologists have pointed to the positive benefits which religious faith may have in the individual's life and have argued that, therefore, faith is an essentially healthy adjustment to life's conflicts and dilemmas. This is the view taken by Thouless, when he states:

"There is, however, a good reason why religious redirection of the libido is not considered pathological, for, unlike the neurotic symptom, it provides a permanent and satisfactory solution of the erotic conflict".⁽¹⁾

So, in this view, religious faith has the positive effect of providing a solution to conflicts provoked by instinctive desires and needs. Ostow and Scharfstein take this concept further when they put forward the view that faith is a manifestation of an instinctive "need to believe", a religious impulse intrinsic to human nature, and that satisfaction of this need is essential to health:

"Belief is almost as necessary to humans as eating..... belief is essential to the efficient functioning of a human organism.....We have the need to believe, and it is futile to think that many of us can be happy though thoroughly sceptical".⁽²⁾

These writers also argue, in challenging the faith-neurosis hypothesis, that satisfaction of this basic need provides a healthy redirection of undesirable impulses to "socially useful purposes".⁽³⁾

Not far removed from this view is the case argued by O.H. Mowrer against the "biologising" of psychology and against the psychoanalytic interpretation of religious belief. He contends that psychoses and

(1) R.H. Thouless, Introduction to the Psychology of Religion (Cambridge Univ. Press 1923), p. 277.

(2) M. Ostow and B.A. Scharfstein, "The Need to Believe", in O. Strunk, op.cit., p. 190.

(3) Ibid., p. 192.

neuroses are properly understood as moral disorders, "diseases of conscience", which may be precipitated by real or imagined offences against the person's conscience.⁽¹⁾ From this starting point, on the principle that fear and guilt is present in every form of mental illness, he goes on to argue that only religious faith facilitates the expiation of guilt through catharsis, fellowship, and forgiveness and serves the healthy purpose of strengthening the individual's conscience against the assaults of instinctive desires. He claims that:

".....evidence suggests that religion, as an institution, has survived for the reason that it often has unique psychological survival value for the individual".⁽²⁾

In each of these cases, far from being a potentially destructive source of repression and loss of freedom, faith is seen as a force or instinct which may resolve conflicts, afford happiness, redirect unacceptable instincts toward socially positive purposes, facilitate the expiation of guilt, and bolster the individual's conscience, and which is therefore an essential characteristic of healthy adjustment. A curious logical extension of this argument is that the ultimate truth of faith, and to some extent the content of faith, is almost irrelevant; the essential healthiness or unhealthiness of religious belief is based upon what seems to be a purely pragmatic and utilitarian evaluation of its effects. Faith is simply a beneficial means to the end of human survival.

A compelling alternative to the "faith-neurosis" and "faith-

(1) O.H. Mowrer, The Crisis in Psychiatry and Religion (Van Nostrand, 1961).

(2) Ibid., p. 11.

instinct" hypotheses, is the argument that religious faith is an expression of man's striving for ultimate meaning and purpose and that the experience of faith provides an essential "framework of meaning" (Cf. G.W. Allport, 1955)⁽¹⁾ and integrates all other dimensions of personal life. The principle underlying this perspective is that man has an instinctive "will to meaning" (Cf. V. Frankl, 1946) and that a structure of meaning to which he can relate his existence is essential to ultimate wholeness. Many writers have taken this position (viz. Boisen, Jung, R. May, G.W. Allport, Frankl, Gotthard Booth, W. Oates, among them) and it is a fundamental component, for example, in G.W. Allport's theory of personality development:

"The error of psychoanalytic theory lies in locating religious belief exclusively in the defensive functions of the ego rather than in the core and centre and substance of the developing ego itself. While religious faith fortifies the individual against anxiety, doubt and despair, it also provides the forward intention that enables him at every stage of his becoming to relate himself meaningfully to the totality of Being".⁽²⁾

An important corollary of this concept is that the essential healthiness or unhealthiness of a particular religious faith is not solely dependent upon its existential, empirical effects. The content, meaning and truth of any form of faith are essential to its healthiness. The question is whether or not it in fact provides a meaningful structure for human existence. If this principle is accepted, then the way is open to establish criteria by which healthy and unhealthy religious beliefs and practices might be differentiated and to adopt a view in which religious faith may have both beneficial and detrimental forms and effects in personal life.

(1) G.W. Allport (1955), op.cit., p. 75 ff.

(2) Ibid., p. 96.

These hypotheses which relate faith to health in an essential and ultimate sense, whether as a neurotic adjustment or as an instinctive need or as a source of meaning, pose insurmountable methodological problems and defy empirical verification. On each side, the case is based upon abstract, a priori arguments which raise the much larger issues of the form of reality and the nature of man and his existence, and a faith or a philosophical assumption regarding the nature of man lies behind each point of view. But the implications of this debate for the health of clergymen are considerable and this discussion will be resumed in the following chapter when considering the nature and meaning of health.

Complementary to these essentialist views are those hypothetical formulations in which religious faith is regarded as a causal factor in either mental health or mental illness. On one side, it has been argued that religious faith is an active agent in causing mental and emotional disorders. It has sometimes been supposed that the prevalence of religious content and imagery in the disturbed ideas and delusions of psychotic patients supports this contention. To substantiate this hypothesis, however, it would be necessary to demonstrate that psychotics were unusually religious prior to breakdown or else to show that neurotic complaints and psychotic breakdowns were more common among religious believers than among those with no such beliefs. More specifically, one would expect clergymen of all people to have an unusually high incidence of mental illness. Having surveyed the evidence, M. Argyle concludes that "the theory that religion can be a cause of disorder is given little support by clinical material" and that "there is no evidence that psychotics were unusually religious

before breakdown".⁽¹⁾

Conversely, it has been claimed that religious belief actively promotes mental health and has positive therapeutic value. Weatherhead firmly adopts this view: "The forgiveness of God is in my opinion, the most powerful therapeutic idea in the world".⁽²⁾ O.H. Mowrer, referred to earlier, is also convinced of the therapeutic value of the Christian faith as a means of alleviating guilt and fear through catharsis, forgiveness, and fellowship.⁽³⁾ If this hypothesis is valid then religious believers, including clergymen would presumably be less prone to psychoneurotic and psychotic disorders and would enjoy a greater degree of integration and adjustment than non-believers. However, this point of view, like its opposite, has been supported by anecdotal material and selected data and no causal links between religious belief and mental health or illness have been established beyond all doubt. The evidence is inconclusive, but, if anything, it tends to support the hypothesis that some kind of faith contributes to personal health. As a psychiatrist, Gotthard Booth has observed:

"It is beyond the competence of the psychiatrist to decide whether the health of a devout Christian or of a militant atheist is better, but he has theoretical and empirical reasons to believe that either one is healthier than the person who has found nothing in the world for which he wants to live and die."⁽⁴⁾

Dr. Booth's opinion has obvious affinities with the view that a sense of

(1) M. Argyle (1959), *op.cit.*, p. 117.

(2) L.D. Weatherhead (1951) Psychology, Religion and Healing (Hodder & Stoughton, 1963), p. 388; also see p. 47.

(3) O.H. Mowrer, *op.cit.*, p. 44 ff.

(4) P.B. Maves (ed.), *op.cit.*, p. 15.

purpose and meaning is essential to health and that a faith, religious or otherwise, may provide such a necessary framework for all other dimensions of personal life.

These causal theories are often presented by their advocates as if they were exclusive opposites: faith is either conducive or detrimental to mental health. However, to anticipate the view adopted here, it seems necessary on both logical and empirical grounds to reject both exclusivist extremes. Alternatively, the effects of a religious faith and vocation may be both healthy and unhealthy depending upon the ways in which these beliefs are appropriated, introjected, understood, and expressed in the experience of the individual person. As in other dimensions of health, the relationship between faith and health is ambiguous and variable. A.A. Schneiders has remarked: "Undoubtedly, faith may at times make a man whole, but it seems also at times to tear him apart",⁽¹⁾ and he argues that religion often causes psychic difficulties and that, paradoxically, it can also promote psychological health.⁽²⁾ If this perspective has any foundation, and it is widely accepted in both psychology and theology, then one would expect religious believers to be neither more vulnerable to mental illness nor to enjoy greater mental health than their fellows. Moreover, if religious faith can have healthy and unhealthy aspects it then becomes necessary to establish criteria by which healthy and unhealthy religious concepts and practices may be effectively differentiated.

(1) A.A. Schneider, "Religion and Psychological Health", Journal of Societal Issues, Vol. 1, No. 1, 1964, p. 13-14.

(2) Two further discussions in which the healthy and unhealthy forms of religious belief are differentiated are provided by W.E. Oates, Religious Factors in Mental Illness. (Association Press, 1955) and M. Millar, "Mental and Spiritual Wholeness", Journal of Societal Issues, Vol. 1, No. 1, 1964.

In view of the religious faith and the specific vocation of clergymen, the implications of these essential and causal theories which relate religious faith to health or illness are self-evident. But, as noted earlier, little attention has been devoted to the relationship between the clergyman's beliefs and vocation and his personal health.

Hence, from a consideration of hypothetical possibilities, a number of intriguing questions emerge with respect to the health of clergymen. Our attention is drawn to the relative significance of occupational conditions and factors, typical personality characteristics, and religious vocation, and to the interaction between occupation, personality, and vocation as dimensions of the individual clergyman's life, as contributory factors in clergymen's experience of health and illness. But whether any of the hypotheses proposed by various investigators are applicable to the experience of Church of Scotland ministers in particular must remain a matter of speculation for the time being. It will be our primary task to attempt to establish the facts of their health experience and then to return to hypothetical possibilities at a later stage.

CONCLUSION AND SUMMARY

In the preceding discussion we have attempted to establish the background of historical developments, empirical research, and hypothetical discussion against which this project has been conducted and which motivated its instigation.

From the historical background, we have seen that the long-standing conviction which associated clergymen with a relatively high degree of health had its origins in the context of 18th and 19th Century Europe and was established by the work of eminent demographers and

vital statisticians of that period. It would seem that Protestant clergymen in Europe enjoyed remarkable longevity. The confidence which this fact engendered was further reinforced by the reports of the Registrar General for England and Wales, and to a lesser extent by those of the Registrar General for Scotland, on occupational mortality. From these reports it became apparent that clergymen in Britain, especially Anglicans and other Protestant ministers, have had one of the lowest death rates and have had a life expectation significantly above the male population and most other professional groups. So any confidence in the health of clergymen appeared to be justified up until the 1950's.

However, we have seen that by the mid-1950's, this widely held assumption was being seriously questioned and concern was being expressed that the health of clergymen was deteriorating to a significant extent. This concern and alarm has also been evident within the Church of Scotland, and has culminated in a petition to the General Assembly seeking sabbatical leave for the Church's ministers to provide an opportunity for relaxation and refreshment. But despite this concern, founded on scanty evidence, contradictory opinions have been expressed as to whether the health of clergymen has declined appreciably in actuality. This project, therefore, has been conducted against a background of conflicting opinions and evidence, but against a contemporary Scottish background marked by growing anxiety for the health of ministers in this country.

It has been seen too that some of the alarming claims made in the mid-1950's, together with increasing appreciation of the far-reaching implications of health for the ministry, had the positive effect of stimulating more systematic research than had been conducted

previously. Confronted by these claims, it was no longer possible to take the health of clergymen for granted. In general the results of research, chiefly conducted in the United States, have been positive and tend to confirm the established relationship between health and the ministry and to refute the claims of serious deterioration. Studies of their physical health, usually in the form of mortality studies, have been remarkably encouraging and indicate that Protestant clergymen still enjoy an unusually low death rate. The only disturbing feature of such data has been the high incidence of death from coronary heart disease among clergymen, which, nevertheless, compares favourably with other professional groups. The incidence of mental, psychoneurotic, and personality disorders has not been excessive in most groups of clergymen; and in some cases it has been reported that clergymen have a greater degree of total adjustment and emotional stability than comparable groups in the population. The most commonly observed mental, emotional, and personality disorders in groups of clergymen are those associated with guilt, intro-punitiveness, social isolation and emotional detachment, depression and anxiety, and sexual difficulties and deviations. However, there is an almost total research-vacuum as far as the health of Scottish clergymen is concerned and it is doubtful whether or how far research conducted elsewhere is applicable to their experience as a group. Such research is, nonetheless, suggestive and the project reported here has been carried out against this background of a growing body of research.

Attempts have been made to explain the distinctive illnesses and complaints suffered by clergymen and these hypothetical formulations tend to fall into three categories. The first are those in which clergymen's afflictions are chiefly attributable to occupational factors

and conditions and are regarded as being, in a sense, occupational diseases provoked by occupational conditions, stresses, or conflicts. The second are those in which the occupational problems and the illnesses experienced by clergymen are the product of typical personality characteristics and unresolved intrapersonal conflicts carried over from the past. These two possibilities are not necessarily exclusive and some writers argue that occupation factors and personality characteristics are inextricably bound-up in a dynamic inter-action and that both are influential in creating the health hazards to which clergymen are most vulnerable. The central, and possibly insoluble, dilemma is whether occupational conditions of the ministry produce typical personality characteristics and conflicts or whether a particular type of person is attracted to the ministry and then precipitates the typical occupational conflicts experienced by clergymen. Be that as it may, most investigators have centred attention upon unresolved personality conflicts and upon the problem of professional identity-diffusion as being major sources of difficulty and illness for many clergymen. The third possibility is that clergymen's religious faith and specific religious vocation may have an influence on their experience of health, either in an essential sense or as a causal factor in health or illness. Some attempts have been made to explore the relationship between religious vocation and personality characteristics and unconscious motivation. But in general, the implications of this aspect of the clergyman's life for his personal health have been avoided or treated with caution, probably because of the conceptual and methodological problems which they introduce. However, these intriguing questions must be put aside until the facts have been established.

Against this background, it was decided that the primary purpose of this project should be to undertake a systematic fact-finding investigation. Unless this was done, any discussions of the health of Church of Scotland clergymen could be nothing more than speculative and impressionistic, based on completely inadequate evidence.

Four "popular" assumptions or propositions emerged from these early considerations which provide explicit focal points for this inquiry:

(i) that Church of Scotland ministers, until recent years, have enjoyed an unusually favourable health record by comparison with other professional groups and the male population and that there has been a clear association between the ministry and health;

(ii) that the health of Church of Scotland ministers has declined significantly in the post-war period, and most particularly in the last decade;

(iii) that the deterioration is manifest in every dimension of their experience: physical, intrapersonal, interpersonal, and vocational;

(iv) and that the decline has been caused by an increase in the mental and emotional stresses and conflicts to which these ministers are exposed in the conduct of their profession and by confusion concerning the professional role they are expected to fulfil.

Whether these propositions have any factual substance ought to be questioned and they provide the focal points for the kind of inquiry proposed here and place some limits on the field of study. But, having circumscribed the field of study, we have now to consider the criteria by which health may be evaluated.

CHAPTER 3

THE CONCEPT OF TOTAL HEALTH

"Health is fragmentary in all its forms. Manifestations of disease struggle continuously with manifestations of health, and it often happens that disease in one realm enhances health in another realm and that health under the predominance of one dimension increases disease under another dimension.Not even the healing power of the Spirit can change this situation."

(P. Tillich, 1963)⁽¹⁾

The elusive and ambiguous quality of health, either as the goal of human life or as a subject of study, is conveyed in this statement by Paul Tillich. Health has been aptly described as a "mirage"⁽²⁾ because, within the conditions of existence, no absolute state of health or wholeness is even attained in actuality. Due to its dynamic nature, health seems to defy definition or objective measurement and, like the process of human life of which it is the reflection, evades all attempts to confine it to a conceptual straight-jacket.

Nevertheless, it is an indisputable fact of personal experience that man seeks to attain a state of health, or wholeness and the polar tension between health and illness, between integration and disintegration, between self-affirmation and self-negation is a phenomenal and experiential fact of human existence. This is no abstraction. For all the semantic, epistemological, conceptual and methodological dilemmas which it poses, man's attempts to maintain relative health and his striving for ultimate wholeness in spite of the relative threat of illness and the ultimate fact of death is an observable fact of human existence. But, as a finite being, for whom biological extinction

(1) P. Tillich (1963), Systematic Theology, Vol. 3 (Nisbet, 1964), p. 300.

(2) R. Dubos, op.cit.

is an existential inevitability, the ultimate goal which he sets for himself can never be fully attained because "Man is integrated only fragmentally and has elements of disease and disintegration in all dimensions of his being" (P. Tillich, 1957 (b)).⁽¹⁾ This is the 'human predicament' to which the Existentialists refer.

It is equally evident that, for some reason, man chooses to struggle against this predicament and seeks to affirm his existence and to fulfil his potential despite the inevitability of separation, disease and death. "To grow in the midst of danger is the fate of the human race, because it is the law of the spirit" (R. Dubos, 1960),⁽²⁾ so man strives to attain wholeness in spite of the perpetual threat of death and non-being which hangs over his life. This is man's destiny.

But there is ambiguity and paradox in this never-ending process of human life in which man seeks to affirm his potential against the forces which threaten his being. The ambiguity resides in the fact that the wholeness which man seeks is not a substantive entity which can be acquired as a possession or established as an achievement. There can be no conclusion to the pursuit because processes of integration and disintegration are locked together in an ambiguous and dialectical relationship at any moment in the continuous flow of human life. The ambiguity of all life processes is expressed by R. Dubos in these terms:

"Every manifestation of existence is a response to stimuli and challenges, each of which constitutes a threat if not adequately dealt with. The process of living is a continual interplay between the individual and his environment, often taking the form of a struggle resulting in injury and disease.....for the

(1) P. Tillich (1957(b)), "Faith and the integration of the personality", Pastoral Psychology, 8 (72), 1957, p. 12.

(2) R. Dubos, *op.cit.*, p. 221.

stuff of creation is made up of the responses to the forces which impinge on his body and soul."⁽¹⁾

The paradox and irony of this condition is that if, on the one hand, man opts out of the struggle and ceases to respond to the demand for continual adaptation he forfeits his right to life, his 'birthright', and condemns himself to sterility and disintegration; but, on the other hand, once engaged in the struggle man is confronted with the fact that there is no conclusion to the struggle, that his potentiality in terms of health and wholeness can never be fully actualized because "Disease will remain an inescapable manifestation of his struggle" (R. Dubos, 1960).⁽²⁾ It is the ironical destiny of man to affirm his being in spite of his awareness that his life is provisional and contingent and has no ultimate necessity.

Any attempt to clarify the nature of health and illness must be conducted against the broader panorama of the nature of man and his existence. They can never be abstracted from man's concrete involvement and enmeshment in the world in a definite place and time. They can never be confined to an abstract and schematic formula and, as manifestations of the total process of human life, any concept of health and illness can only be partial and provisional. But, given this perspective, some attempt at conceptualization is necessary for the purposes of our inquiry.

DEFINITIVE DILEMMA

Many attempts have been made to formulate definitive or descriptive conceptualizations of health. But health remains elusive and there is much disagreement and misunderstanding over the use of the term. The

(1) R. Dubos, op.cit., p. 11.

(2) Ibid., p. 221.

confusion and the difficulty is illustrated by the following examples; offered by an international health organization, a professor of public health and social medicine, a pastoral theologian, a physician, two writers on social and community health, and a professor of psychiatry respectively, each of whom considers health from a different perspective.

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction....."

The health of all peoples is fundamental to the attainment of peace and security....."

(W.H.O., 1967)⁽¹⁾

"Health (Anglo-Saxon - haelth from haelan, to heal from hal, whole, sound) is a state or condition of an individual or a group that is more easily described than defined, largely for the reasons that in it feelings and behaviour are involved. A person who is healthy not only looks 'well' but also enjoys a feeling of well-being which affects his actions and reactions no less than his attitudes.

.....the healthy individual has a quiet mind, is tranquil, at peace with himself, his neighbour and with the universe at large; he is well adjusted to the circumstances, conditions and content of his external world, being able to maintain an even temper, an alert intelligence, a happy disposition, and to display socially considerate behaviour."

(F.A.E. Crew, 1950)⁽²⁾

"Health is the complete and successful functioning of every part of the human being, in harmonious relationship with every other part and with the relevant environment."

(L.D. Weatherhead, 1951)⁽³⁾

(1) World Health Organization, Basic Documents (16th Edition, Geneva, 1967), p. 1.

(2) F.A.E. Crew, *op.cit.*, p. 1-2.

(3) L.D. Weatherhead, *op.cit.*, p. 315.

"Man can feel healthy only to the extent to which he can relate his existence to values which are beyond his own person.
.....Health is not in the achievement and duration of the isolated individual, but in the relatedness achieved in the world."

(Gotthard Booth, 1953)⁽¹⁾

"The real measure of health is not the Utopian absence of all disease, but the ability to function effectively within a given environment. And since the environment keeps changing, good health is a process of continuous adaptation to the myriad microbes, irritants, pressures and problems which daily challenge man."

(R. Dubos and M. Pines, 1966)⁽²⁾

"Wholeness cannot depend on the abolition of disease, it must be regarded as a spiritual quality available to us now, and integrated unity of the many-sidedness of human personality - the diseased and the healthy, the good and the bad, the wise and the foolish. This unity can only be effected through the unifying power of love.....the selfless love of Agape."

(M. Millar, 1964)⁽³⁾

These statements illustrate the variety of ways in which health may be used and demonstrate the difficulty in formulating an adequate definition for the purposes of systematic inquiry. Perhaps the semantic, conceptual, and methodological problems involved are insurmountable. Admittedly, with the exception of the first, these statements are taken out of the context of more extensive discussions and are therefore open to distortion; but they do highlight the problems involved. The difficulties are associated with a series of conceptual dualities, which

(1) Gotthard Booth in P.B. Maves (ed)., op.cit., p. 17.

(2) R. Dubos and M. Pines, Health and Disease (Time-Life International, 1966), p. 10.

(3) W.M. Millar, op.cit., p. 11.

are frequently posed as if they were exclusive opposites.

Concepts of health can be broadly differentiated, in the first place, according to whether they presuppose a substantive or process theory. Health is sometimes used in a quantitative sense with reference to a 'state' or 'condition', an observable and measurable entity, even if this entity only exists as a statistical norm. Health is something which a person has and he is then presumed to be 'healthy'. But the assessment of a person's healthiness is dependent upon the criteria by which health is identified; so that what appears to be a normative expression is in fact a qualitative value-judgment. Alternatively, health is used to describe a process or activity, a 'continuous process of adaptation'. Health then is not something which a person has but is a reflection of all that a person is and a manifestation of the way in which a person used his existence. But there must be some basis for making a qualitative differentiation between healthy adjustment and maladjustment. Whether health is used in a substantive or dynamic sense, any statement about the nature and meaning of health is inextricably evaluative because it involves questions associated with human values, goals and ideals.

A second contrast between concepts of health is apparent in the distinction between dimensional and holistic conceptualizations. The dimensional perspective operates on the principle that the individual person is an aggregate of a number of distinguishable and separable components and that health can only be assessed in terms of the efficient functioning of particular elements. In effect, health is reduced to divers categories, each with its distinctive characteristics: physical health, mental health, spiritual health, community health, and so on. The distinction between substantive and process theories applies

in each of these fields and is most evident with respect to concepts of 'mental health' and 'mental illness'. The question whether 'mental illness', specifically the psychoses, is a condition or state which a person has in the sense of being a disease with a physico-chemical genesis or whether it is purely a symptomatic expression of what a person is has been the subject of vigorous debate.⁽¹⁾ Moreover, the assessment of different categories of health is no less evaluative. The quantitative expression 'mental health', for example is in fact a disguised value-judgment derived from the qualitative expression 'a healthy mind'. But what are the characteristics of a healthy mind? That is open to dispute.

Taken to its logical and absurd conclusion, the dimensional perspective suggests that there is a healthy body apart from a healthy mind, a form of mental health apart from physical well-being, and that both the physical and mental dimensions of a person's being can be evaluated apart from the total experience of the whole person. Conceptual abstraction and fragmentation of this kind is fostered and encouraged by the proliferation of specializations in our time. Each specialization tends to claim exclusive rights to a particular territory for the purposes of scientific inquiry and in some instances tending to claim exclusive validity in the realm of health and healing.

The reduction of man into constituent parts may serve the interests

- (1) For example, in a stimulating discussion T.S. Szasz, The Myth of Mental Illness, op.cit., takes issue with the substantive conceptualization of mental illness, which generally assumes that all forms of mental distress and disturbance have a physiochemical etiology. The debate between physiogenic and psychogenic theories as to whether mental illness is a disease as such is particularly vigorous, for instance, with reference to 'endogenous' depression and also schizophrenia. F.A. Macnab, Estrangement and Relationship (Tavistock, 1965), p. 89 ff provides a summary of the main theories put forward to explain the causation of schizophrenia which clearly illustrates the confusion and conflict.

of strict scientific objectivity, but this procedure is also the source of much disagreement and conflict. The conceptual splitting of the person and his world into a host of dimensional fragments leads to the rival claims made on behalf of chemical, psychological and spiritual ways of healing. It is the source of interminable disputes concerning the primacy of body over mind or of mind over body or of spirit over mind and body. It underlies the disagreements over whether man is essentially a biological specimen, a zoological species, a social animal, or a spiritual being. Each of these issues is of fundamental importance in considering the nature of health. But so long as these dimensions are abstracted from the totality of the person and his world and so long as one or another specialization claims primacy or exclusive validity in understanding man and the nature of health then such conflict and confusion cannot be resolved.

The holistic perspective, which has been gaining recognition in various branches of science, ⁽¹⁾ insists that health can be understood only with reference to the person as an integral whole and any attempt at conceptualization must begin with recognition of the totality of a person in relation to others and in a particular world. Without this fundamental framework any concept of health is bound to be partial and inadequate, if not distorted. An inquiry which takes any other starting-point must be less rather than more objective, despite claims to the contrary, simply because it is not faithful to the facts of human

(1) I.G. Barbour, Issues in Science and Religion (S.C.M., 1966), p. 327 ff., considers the growing contribution of holism to scientific inquiry with special reference to the work of J.C. Smuts, J.S. Haldane, and W.E. Agar. R.A. Lambourne, Community, Church and Healing (D.L.T., 1963), p. vi, also makes mention of the growing emphasis on the need for a holistic approach to medicine. One of the earliest and most influential discussions of the application of holism to scientific inquiry is that of J.C. Smuts, Holism and Evolution (Macmillan, 1926).

existence. Although different elements in the total make-up of a person may be identified, none of these elements, as a matter of empirical fact, has a separate existence apart from other parts or apart from the experience of the whole person.

If a holistic view, which transcends the traditional objective-subjective dichotomy, is accepted then health is understood in terms of the dialectical relationship between the whole and its parts, in which the whole is affected by its parts, parts are affected by the whole, changes in one part may influence other parts, and in which there is mutual causal interdependence and interaction between the whole and its various parts.

Underlying dimensional and holistic approaches to health and to the study of man is a third conceptual split between mechanistic and personal attitudes and procedures. These represent diametrically opposed philosophies of man and his existence.

At its extreme, a purely dimensional perspective perpetuates a rigid line of demarcation between specializations and between the various agencies of healing. Based on the illusion of absolute scientific detachment, this perspective expresses a materialistic 'world-view' and a mechanistic view of man. A person is essentially a complex machine whose healthiness can be examined and evaluated in terms of the efficient functioning of its various components and whose operation can be exhaustively explained by natural causation according to the laws of physics, chemistry, biology, and other natural sciences. The fact that each of these abstract elements or faculties are only aspects of the same integral whole seems to be incidental or irrelevant.

The mechanistic fragmentation of a person and his world results in a reductionistic, stunted image of man and can only end in an inadequate

and totally erroneous concept of health. G.W. Allport is one of many who have reacted against such reductionism:

"Up to now the "behavioural sciences", including psychology have not provided us with a picture of man capable of creating or living in a democracy. These sciences in large part have imitated the billiard ball model of physics, now of course outmoded. They have delivered into our hands a psychology of an "empty organism", pushed by drives and moulded by environmental circumstances".⁽¹⁾

One of the few voices of protest in Britain has been that of R.D. Laing, who has persistently exposed the denigrating and dehumanizing effects of studying and dealing with persons as though they were mindless, inanimate objects. The essence of his critique is congenitally stated in The Divided Self, his study of schizophrenia:

"Seen as an organism, man cannot be anything else but a complex of things, of its, and the processes that ultimately comprise an organism are it-processes.We shall be concerned specifically with people who experience themselves as automata, as robots, as bits of machinery, and even as animals. Such persons are rightly regarded as crazy. Yet why do we not regard a theory that seeks to transmute persons into automata or animals as equally crazy?"⁽²⁾

These criticisms do not deny or denigrate the value of any specialist's contribution to our understanding of particular areas of human existence and of specific aspects of man's health. There is no doubt that the physiologist, biologist, zoologist, social psychologist, sociologist, and others engaged in human sciences greatly enrich our understanding of man in so far as man is an organism or animal or social creature. Each has a specific function

(1) G.W. Allport, op.cit., p. 100.

(2) R.D. Laing (1960), op.cit., p. 22.

and operates within definite limits. However, in his scientific capacity, the specialist is not in position to make assertions about the nature of man qua Man as if these assertions were statements of scientific truth. As soon as the scientist employs scientific particulars to make assertions about the essential nature of man he has moved from the realm of scientific truth into the realm of essential truth, the truth of faith. This, of course, he is entitled to do on the basis of his personal beliefs but not on the basis of scientific authority.

There has been a considerable reaction against the deterministic and mechanistic extreme in the study of man and health, which assumes that man is nothing but a machine or organism or animal and that the whole of reality can be reduced to mathematical, chemical and biological constructs. The alternative view, adopting a larger perspective in the field of human sciences, may best be described as personal. It is argued that particular aspects of health, functional, affective, spiritual, or interpersonal, can only be understood with reference to a larger level of organisation which transcends and embraces each of them, namely the person as an integral whole. Health and illness are never experiences of a mindless body or of a disembodied mind or of a transcendental spirit. They are always experiences of a person.

The crux of the definitive dilemma with reference to health is that much more is at stake than matters of empirical, scientific fact. What is at issue in each of these conceptual dichotomies between substantive and dynamic theories, between dimensional and holistic orientations, and between mechanistic and personal perspectives, is the nature of reality and the nature and destiny of man within the conditions of existence. Essential questions of ultimate significance are unavoidable

since every concept of health implies an answer to the question: What is man? An ideal of ultimate wholeness is implicit in every statement about the nature and meaning of health. Whether it is overt or covert, whether it is based on the universalization of scientific particulars or whether it is derived from abstract arguments, any concept of health implies a philosophy of life and an essential view of man and of his ultimate possibilities. This is the dilemma.

Disagreements and misunderstandings concerning the nature of health revolve around four fundamental issues. The first concerns the nature of reality as a whole. The question is whether human existence can be fully explained in terms of empirical data and natural causation or whether there are aspects of existence beyond the scope of strict scientific observation and measurement. Underlying this issue is the problem of the relationship between the natural and the supernatural, between objective factors and subjective processes, between empirical facts and essential possibilities, and between scientific truth and the truth of faith.

The second fundamental issue concerns the essential nature of man, his place and destiny within the conditions of existence, and the extent to which his existence is patterned or purposive, determined or free. Every attempt to define or describe ultimate human possibilities implies an answer to this crucial issue.

Then, thirdly, the problem of evil within the conditions of existence is inescapable for all who seek to understand the human predicament and to identify the basic causes of suffering, disease and death. What is the basic cause, if anything, which threatens the person's wholeness and integrity and which results in illness, division, disease and disintegration? Indeed, can any single theory account for

all forms of disease or are there many processes of disintegration all of which reflect a more basic fault in the structure and conditions of existence?

An ancillary, but no less crucial problem concerns man's relationship to himself as the subject-object of his own inquiries. In studying his own nature and in considering the meaning and ultimate goal of his life, man is never a detached observer, he is inextricably a participant. As a participant-observer he is never able to catch himself unawares like other objects of his study. This capacity for detachment, for self-transcendence, is in itself indicative that man has at least partial freedom from the natural determinants to which he is subject. No scientific inquiry would be possible without this freedom. At the same time it poses a dilemma for all social and human sciences.

These eternal problems are implicit in every consideration of the nature and meaning of health, even if they are not always recognized or acknowledged, and are at the root of all conceptual disagreements present in such discussions. The fundamental dilemma with respect to health and illness is the problem of understanding man's existence and life itself.

AN EXISTENTIAL-ONTOLOGICAL PERSPECTIVE

The concept of Total Health which is intrinsic to the framework of this study is derived from an existential-ontological perspective; that is, one in which existential and essential truth are correlated and reconciled without reduction of either form of truth. The concept of health which emerges is dynamic, holistic, multidimensional, and personal in character.

In the first instance, this perspective is existential. That is to say, it is concerned with human existence, with the fact that a

person is, that he exists, and it attempts a detailed examination of human existence in its totality and in all its specificity. Existentialism is a philosophy that confronts the human situation to uncover the basic conditions of existence and to ask how man can actualize his potentiality and how man can establish or discover his own meaning within these structures.⁽¹⁾

But existentialism is not abstract or schematic. As an inquiry into the nature of human existence it accepts no a priori, abstract preconceptions about the essential nature of man, no prefabricated human nature which ossifies human possibilities according to a preordained mould. It begins instead with the concrete and living reality of a person-in-his-world in a particular time and space.⁽²⁾ To use the philosophical formula: existentialism is based on the principle that "existence precedes essence".

Operating from the foundation of personal existence and experience

- (1) Existentialism cannot be properly described as a 'school' with a consistent or unified line to argue. It is more correctly understood as a 'movement', and those engaged in this movement simply have a common starting-point, that is human existence in all its dimensions, the living and concrete experience of the person. In its very nature, human life cannot be enclosed or trapped in a schematic system. Human life is a dynamic, moving-target which moves on into the future and therefore any system or 'philosophy of life' can only ever be provisional, never absolute. It is in the nature of existential inquiry to continuously open up new areas of human experience recognizing that every insight gained is provisional.
- (2) Because existentialist inquiries are primarily concerned with the communication of experiences rather than ideas the most common, and possibly the most effective, expressions of existentialism are found in poetry, drama, novels and art: as in the work of Kierkegaard, Dostoevsky, Sartre, Kafka, Camus, Moravia, and to some extent in the poetic prose of Buber, each of whom explore particular areas of human experience. Although attempts are made to express existential concepts in formal philosophical terms, as by Tillich, Buber, Kierkegaard, Heidegger, Jaspers, Marcel, Maritain, and Berdyaev, these attempts meet with varying success and existentialism tends to lose something of its dynamism when formally systematized.

"existentialism attempts to widen the scope of any appraisal of reality"⁽¹⁾ by transcending the traditional subjective-objective dichotomy. Existentialism expresses a protest against the claims made for the exclusive and universal validity of objective reason and scientific truth, and is opposed to what amounts to 'scientific imperialism'. Furthermore, it is a reaction against the mechanistic determinism which reduces man to the status of an object or a conglomerate of things. This does not mean, however, that existential analysis is a form of irrationalism or that it abandons objectivity in favour of subjectivity. It is founded on the conviction that scientific truth is only one of many forms of truth and that man cannot be explained in his totality by the natural sciences. Therefore, existential analysis attempts a balanced appreciation and correlation of objective factors and subjective processes in human experience, and in this way opens up a larger perspective which is more faithful to the facts of human existence than 'mere' objectivity.⁽²⁾

From an existential point of view, there are vital areas of personal experience and human life to which scientific inquiry has limited or no access. In the very act of examining and questioning

(1) F.A. Macnab (1965), *op.cit.*, p. 133.

(2) A common criticism of existentialism is that it represents 'mere subjectivity' in opposition to reason and objectivity and is based on a purely emotional and personalistic appraisal of reality. This misconception is reflected by I.G. Barbour, *op.cit.*, p. 115-120, when he equates existentialism with subjectivity and a subject-centred approach to knowledge by contrast with scientific detachment and object-centred inquiry. If this were so then there would indeed be an irreconcilable rift between existentialism and science with no conceivable point of contact. In fact existentialism is concerned with both objective facts and subjective processes as fundamental aspects of human existence and is an attempt to bridge the subjective-objective dichotomy, as is argued by F.A. Macnab (1965), *op.cit.*, p. 129-140, and is close to the view for which Barbour himself argues (*op.cit.*, p. 176-188).

his own existence, man demonstrates his potential for self-transcendence, his capacity to "ex-ist", to stand out or beyond himself; and any appreciation of human life which leaves out this quality of self-transcendence states less than the truth about the nature of man. Man is not simply the helpless object of natural determinants or the docile recipient of 'divine-grace' for that matter.⁽¹⁾ Man is also a mindful, intentional, and active agent with a capacity for self-transcendence and with a measure of responsibility for the way in which he uses the conditions of his existence. The very fact that man is both subject and object of his own inquiries is a manifestation of this paradoxical aspect of human existence. Existentialism is as much concerned with the transcendent or spiritual quality of man's life as it is for objective facts.

Existential analysis in itself, however, can do no more than explore the human situation and illuminate the basic structures of existence. It exposes the 'questions' thrown up by existence but existential inquiry in itself cannot provide the 'answers'.

Any analysis of human life inevitably comes up against eternal questions about the essential nature of reality and about the ultimate meaning and goals of man's life. There comes a point when it becomes necessary to bridge the distance between existential actualities and

- (1) It is ironical that the scientific and theological extremes, which are mutually exclusive, assume equally deterministic 'world-views'. According to the scientific extreme, exclusive validity is claimed for empirical truth, the whole of reality can be explained in terms of natural causation, the only free agent is 'nature' operating within the boundaries of 'natural law', and man is the helpless object of natural determinants. According to the theological extreme, exclusive validity is claimed for revealed truth, God is the only free agent operating according to 'divine-law' with some latitude for 'sinful' rebellion against his will, and man is the docile recipient of divine grace. Existentialism is in opposition to both forms of absolutist determinism and resists absolute assertions about human life of either kind, whether naturalistic or supernaturalistic.

essential possibilities, between the finite and the infinite, by asking whether or not human life has any essential meaning or points to any ultimate goal. Once again, the very fact that man can and does question his existence and looks forward to consider ultimate possibilities is indicative of his capacity for self-transcendence. At this point, in the act of seeking to answer the questions posed by the conditions of his existence, man is driven to transcend himself and to enter the realm of ontology and essential truth. It becomes necessary to correlate the existential and the ontological.

"It is the function of an ontological concept to use some realm of experience to point to the characteristics of being-itself which lie above the split between subjectivity and objectivity, and which therefore cannot be expressed literally in terms taken from the subjective or objective side. Ontology speaks analogously."

(P. Tillich, 1952)⁽¹⁾

The existential and the ontological are correlative and are dialectically inter-related. Life is "the actualization of potential being" (P. Tillich, 1963)⁽²⁾ and the existential is only because it is the actualization of ontological possibilities. But the existential actuality is always fragmentary and incomplete because it is subject to the conditions of existence and is therefore open to distortion and disintegration. However, the ontological potentialities which lie behind existential actualities cannot be known in and of themselves. The ontological can only be apprehended and known from within the conditions of existence in so far as it is revealed or discloses itself through existential actualities. Therefore, however, the ontological or ultimate can only be partially perceived because the existential

(1) P. Tillich (1952), op.cit., p. 35.

(2) P. Tillich (1963), op.cit., pp. 12, 32.

phenomena through which it is revealed are fragmentary.

From an existential-ontological perspective, any concept of health must be drawn from the realm of human existence and experience, and is therefore existential; but it is also an expression of faith which reflects man's awareness of the ultimate potentialities open to him even if those possibilities are never fully perceived or attained, and it is therefore ontological. Moreover, being derived from the facts and conditions of existence and as an expression of faith, any concept of health can only be partial and provisional.

In formulating a conceptualization of health and illness and in establishing criteria by which they may be evaluated, the influence of R. May, Binswanger, Buber, Frankl, Fromm, A. Storrr, Tarnier, R.D. Laing, R. Dubos, G. Booth, K. Menninger, and most particularly the influence of Paul Tillich will be quite apparent in the following discussion.

THE MULTIDIMENSIONAL UNITY OF LIFE

Any consideration of health and illness can only have one starting-point, namely the unity and integrity of the unique person and the relationship between him and others and between him and his world; or to use Tillich's phrase, it is imperative to begin with the indisputable fact of "the multidimensional unity of life".⁽¹⁾ To refer to the unity and uniqueness of the whole person in a particular world in time and space is not to use a philosophical abstraction; it is a concrete, observable, existential phenomenon.

Given the fundamental priority and unity of the person, health and illness are always experiences of the whole person. Health is the outcome of any happening or process which serves to integrate, affirm and expand the life of the whole person; disease is evident in any

(1) P. Tillich (1963), op.cit., pp. 11-32.

process which serves to fragment, disrupt, negate or disintegrate this unity. In view of the multidimensional unity of life, health and disease are not quantities or qualities which a person has or possesses; they are rather expressions of what a person is and are manifestations of his being-in-the-world with all its dimensions.

Fundamentally, health is characterized by self-affirmation and integration, while disease is characterized by self-reduction, self-negation, and disintegration.

It should scarcely be necessary to stress the unity and integrity of the person as our starting-point. However, although this fundamental fact is readily acknowledged in principle, it is not so readily accepted or employed in practice. With reference to general practice in medicine, M. Balint has observed:

"Nowadays everybody preaches that when a patient is ill the whole person is ill, not only his skin, his stomach, his heart, or his kidneys. This truth, while constant lip-service is paid to it, is unfortunately ignored in every day medical practice".⁽¹⁾

This is not an isolated criticism and has been echoed by others.⁽²⁾

Whenever health and illness are detached from the larger perspective of the whole person misunderstanding and disputes

(1) M. Balint, op.cit., p. 94.

(2) For instance, in the introduction to M. Hamilton, Psychosomatics (Chapman and Hall, 1955), p. vii, Prof. J.R. McCalman states: "Much is written and taught about the fundamental unity of mind and body, yet the very one-sided training which the medical student receives does not encourage him to think habitually of a real unity. Is he not, rather, influenced by the very nature of his training to think first of the ways in which the body can affect the mind and then, belatedly, to consider the reverse effect? Does not a vague but powerful materialistic dualism pervade all the teaching he receives?"

In the same vein, one is reminded of the Shattuck proverb: "It is sometimes more important to know what kind of fellah has a germ than what kind of germ has a fellah".

inevitably arise. This is most evident in disagreements over the relationship between and relative importance of organic, physico-chemical, personality, emotional, and spiritual factors in the causation of illness and disease, in the conflicts between physiogenic and psychogenic theories of causation, and in the rival claims made on behalf of biochemical, psychological, and spiritual ways of healing.

If the fundamental priority of the person as an integral whole is acknowledged then health and illness always refer to the existence and experience of a person and not just to a body, mind, emotional complex, or a spirit. Seen from this perspective it is possible to transcend the subjective-objective duality, the body-mind dichotomy, the id-ego-super ego trichotomy, or any other conceptual polychotomy. It is then unnecessary to adopt exclusivist either/or positions with respect to health and illness. There is room to accept a member of paradoxical both/and postulates in which the person's existence is both patterned and purposive, both separate and related, both homeostatic and dynamic.

So, in the first instance, we will be concerned with health and illness as processes of integration and disintegration in the experience of the person as an integral whole.

THE HUMAN SITUATION⁽¹⁾

The very fact of the person's existence demands an encounter with others and with the world, which necessitates a continual process of adaptation and adjustment. The person has his being in a particular world and under these conditions his unity and integrity is constantly threatened and is exposed to possibilities of distortion, disruption, and disintegration and ultimately to the fact of death. Health,

(1) F.A. Macnab (1965), op.cit., pp. 141-163, provides a most helpful summary of the contributions made by Heidegger, Buber, and Tillich to our understanding of the human situation.

therefore, is relative to and contingent upon the conditions of existence in which the person participates, to which he is subject, and by which he is bound. Health and illness, self-affirmation and self-negation, are manifestations of the person's responses to the structures of his existence.

(i) Estrangement

The tragic and universal condition of man is that the person is always estranged from his potential being. Under the conditions of existence, the person's unity is constantly threatened, relatively by illness and absolutely by death, and his essential potentialities are never fully actualized and self-integration is never absolutely realized:

"The process of self-integration is constitutive for life, but it is so in continuous struggle with disintegration, and integrating and disintegrating tendencies are ambiguously mixed in any given moment".

(P. Tillich, 1963)⁽¹⁾

In the continuous flow of life, processes of health and disease, wholeness and fragmentation, integration and disintegration are ambiguously mixed in the person's total experience; and this contrast between what one is and what one could become constitutes the state of estrangement in which man exists and of which he is aware.

(ii) Finitude

Overshadowing man's life and underlying man's estrangement from his potential being is the universal condition of finitude. The person has his being under the constant threat of non-being⁽²⁾, and, as a

(1) P. Tillich (1963), op.cit., p. 37.

(2) P. Tillich (1952), op.cit., pp. 40-2, 58-61, 152-5, 171-5, et al. Tillich makes frequent use of the concept of non-being or non-existence. From the point of view of linguistic analysis it appears to be nonsensical: how can no-thing be something? Tillich argues (Ibid., p. 48) that it is logically necessary as the

finite creature, the condition of finitude is experienced relatively in disease, injury, and illness, and absolutely in death. Disease and death are expressions of non-being and are manifestations of man's finitude.

Death of course is nothing and has no quality in itself. It is therefore a logical absurdity to describe death as an event of life or as something which is lived through or experienced. Nevertheless, death is brought into the present and makes its impact on a person's life, even though it is no-thing, as an anticipated possibility which marks off the boundary of the future and which represents the cancellation of all future possibilities.⁽¹⁾ In Tillich's words:

".....death stands behind fate and its contingencies not only in the last moment when one is thrown out of existence but in every moment within existence".

(P. Tillich, 1952)⁽²⁾

Man's existence then is "being-toward-death"⁽³⁾ and death is the mark of his finitude and of the ultimate negation of his being.

All forms of disease and disintegration are then manifestations of man's finitude and carry with them the threat of non-existence:

negation of being and that "there could be no negation if there were no preceding affirmation to be neglected". Furthermore, "In itself non-being has no quality and no difference of qualities. But it gets them in relation to being." (Ibid.) Despite the semantic difficulties involved, man is aware of the fact of biological extinction and of the complete loss of self which death implies. The object of this awareness is non-being. Moreover, this awareness makes an impact on life in the present: "We are not always aware of our having to die, but in the light of the experience of our having to die our whole life is experienced differently". (Ibid., p. 62).

(1) Cf. J. Macquarrie, Studies in Christian Existentialism (S.C.M., 1965), p. 54.

(2) P. Tillich (1952), op.cit., p. 50.

(3) Cf. J. Macquarrie, op.cit., p. 46 ff, in his discussion of Heidegger's analysis of the existential significance of death.

"Every disease has in it the threat of death".⁽¹⁾ Within the existential conditions of estrangement and finitude, which are ontological elements of man's being,⁽²⁾ the person's integrity and unity is constantly threatened and ultimately disintegrates in death. This is the human predicament.

If there is a basic fault, an ultimate cause, which lies behind all disease in human life then it resides in the condition of finitude which is basic to man's existence. The fault is to be found in the fundamental polarity between the finite and the infinite and in the all-pervading tension between being and non-being which are inherent in human existence.⁽³⁾ Any particular fault, whether in the form of a physiological malfunction, an emotional disturbance, faulty programming in the learning process, a paralysing sense of guilt, disrupted inter-

(1) P. Tournier (1954) A Doctor's Casebook in the light of the Bible (S.C.M., 1954), p. 170, quoting Courvoisier.

(2) The conditions of estrangement and finitude are ontological: that is to say, they are essential components of human existence, they are given, built-into the structure of existence and do not represent a "fallen state" from a former state of grace or the destruction of a lost Utopian 'paradise'. This is consistent with the conviction expressed in Biblical mythology (Genesis 2:4-24). Man is placed in the garden (v.8), this world, and is given the capacity to participate in the life of the world creatively and responsibly (v.15). Events prove that man has access to the "tree of the knowledge of good and evil" (v.9; Genesis: 3) and is able to choose how he will use his life. But at no point is it suggested that man is an immortal being with access to the "tree of life" (v.9). Eventually it is explicitly stated that such access is denied him (Genesis 3:22-24). His finitude is a given element of his existence and his being is therefore open to disease, disintegration and to death.

(3) This idea is expressed in Job's enigmatic reply to his wife's anger toward God: "Shall we receive good at the hand of God, and shall we not receive evil?" (Job 2:10). Suffering and pain, disease and death are aspects of man's given existence. This is in contrast to the orthodox Christian view as expressed, for example, by L.D. Weatherhead, op.cit., p. 191: "Nearly all human pain, suffering and disease come from human folly, ignorance and sin.God's will is perfect health of body, mind and spirit".

personal relationships, a profound loss of meaning, or any other specific fault, is always a manifestation of the ontological tension between existence and non-existence and represents the actualization of the power of non-being in human life. From this perspective it becomes unnecessary to adopt or advocate any exclusivist single-cause theory of disease. Illness and disintegration may come from many directions and may take divers forms in human life. But they are always expressions of non-being and reflect the condition of finitude to which man is subject.

In postulating a "basic fault" theory, M. Balint puts forward a similar view although it is expressed in different terms. He suggests that underlying all forms of disease and distress is the fact that the person's narcissistic beliefs in his own inviolability, imperishability, loveableness and capability, established in infancy and childhood, are inevitably eroded under the conditions of human life. He observes:

".....during our mature life our narcissism gets hurt time and again. It is a severe shock to realize, no matter whether suddenly or gradually, that because of illness our body (or our mind) is, for the moment, not capable and perhaps will never again be capable of reassuring us that our hopes are still possible of fulfillment in some unspecified future."⁽¹⁾

The basic fault then lies in the condition of finitude and in man's awareness of the fact that he is not ultimately inviolable or indestructible.

Subject to finitude and in face of the fact of death, man is confronted with existential alternatives. Man may become resigned to his fate and succumb to the power of non-being in his life. He may fall into helpless despair and surrender his potential. Or, in a desperate attempt to thwart the threat of non-existence and to prolong his life,

(1) M. Balint, op.cit., p. 258.

he may restrict his life within secure and narrow defenses and opt for a limited form of self-affirmation. This is the essential character of the neurotic solution to life's problems. Or he may seek to affirm his existence and to fulfil his potential in spite of the omnipresent and universal threat of non-existence. Man is able to transcend the conditions and contingencies of his existence to imagine infinite possibilities and to affirm ultimate potentialities. But the latter alternative requires courage: "Courage is self-affirmation "in spite of", that which tends to prevent the self from affirming itself" (P. Tillich, 1952).⁽¹⁾

It is the ironical destiny of man to affirm his potential in spite of that which threatens his existence while knowing that, in any event, his self-affirmation can only be partial. Health, then, is evident in those processes which affirm human life and the unity of the person as an integral whole in spite of finitude; disease is present in all processes of disintegration and is expressed absolutely in death.

(iii) The Categories of Existence

Man's being is also bounded by the categories of existence, beyond which he cannot go and from which he cannot escape except by ceasing to be.⁽²⁾ These categories are the basic structures or forms of existence which limit the existential actualization of man's potential self-affirmation. The condition of finitude is manifest in each of these categories and, since these categories or structures set the boundaries around a person's life, health and illness are contingent upon them.

(a) Temporality. Man's existence is temporal and the person's life is limited by the central category of time. Although it is possible to

(1) P. Tillich (1952), op.cit., p. 41.

(2) P. Tillich (1954), Systematic Theology, Vol. 1. (Nisbet, 1964), p. 213 ff.

stand outside time through memory, imagination, and anticipation, the limits which it imposes on the individual life are inescapable. The unique individual's time and future possibilities are ultimately closed off by death which is present in every moment:

"Since every day a little life is taken from us - since we are dying every day - the final hour when we cease to exist does not of itself bring death; it merely completes the process."

(P. Tillich, 1952).⁽¹⁾

Awareness of the category of temporality carries with it apprehension of man's transitoriness, dispensibility, and destructibility, and this may be difficult to tolerate or accept:

"In his estrangement man experiences a diminishing tolerance for his temporality; in guilt he remembers his past, in his transitoriness he knows his present, and in apprehension he looks towards his future. He tries to prolong his time, to perpetuate his memory, to ensure his immortality, and in his resistance and despair time takes on a demonic or destructive power."

(F.A. Macnab, 1965).⁽²⁾

Despite man's efforts, sometimes frantic efforts, to gain access to "the tree of life"⁽³⁾ and to suspend or prolong the passage of time, these efforts can only end in futility and defeat. Temporality remains as a basic component of his existence and disease, injury, illness and death are constant reminders of man's subjection to time.

Health and illness are therefore contingent upon and relative to the category of time and breakdown and disintegration are inevitable within time. But the fact of its inevitability makes it no easier to bear. In resisting and rebelling against the category of temporality,

(1) P. Tillich (1952), op.cit., p. 24-25.

(2) F.A. Macnab (1965), op.cit., p. 157.

(3) Genesis 2:9; 3: 22-24.

man may engage in desperate and sometimes subtle attempts to achieve immortality, to prolong his time, to perpetuate his memory, and may repress and close his mind to the finality of his death. Death may be consigned to a vague and indefinite future as something anonymous and innocuous.⁽¹⁾ But, tragically, in seeking to escape from his temporality and finitude man destroys himself.⁽²⁾ In a desperate attempt to evade the passage of time and to preserve himself against the threat of death the person becomes increasingly self-centred and self-absorbed, which leads to the annihilation of his individuality and possibly to the destruction of others. Hence, man's temporality may take on a destructive character.

In an authentic existence, by contrast, there is courageous acceptance of temporality and a resolute anticipation of the fact of personal death: "An authentic existence which resolutely anticipates death and understands all living to be also dying transcends the triviality of everyday existence and achieves unity and meaning". (J. Macquarrie, 1965).⁽³⁾

When temporality and finitude are acknowledged and accepted as inescapable conditions of existence, the person is enabled to face the potentiality of his life more positively and with greater vitality.

(1) Cf. J. Macquarrie, *op.cit.*, p. 55, on the flight from death.

(2) This idea is followed through in detail by N.O. Brown, *op.cit.*, in his consideration of the significance of repression in Freud's later thinking: he says, "...the essence of society is repression of the individual, and the essence of the individual is repression of himself". (p. 3) But the driving-force behind repression is the anxiety of separation, individuality and death (pp. 114-5), and the tragedy of the human condition is that in seeking to escape from his finitude by sublimation, suppression, and repression man in effect destroys himself and represses his own life (p. 101). Man's flight from death, instead of preserving life, is self-destructive: "If death gives life individuality and if man is the organism which represses death, then man is the organism which represses his own individuality". (p. 105).

(3) J. Macquarrie, *op.cit.*, p. 56.

One is reminded of a poem by Dag Hammarskjöld as a young man:

"Tomorrow we shall meet,
Death and I - .
And he shall thrust his sword
Into one who is wide and awake.

But in the meantime how grievous the memory
Of hours frittered away."⁽¹⁾

An open recognition of temporality and of the transitoriness and destructibility of the individual life may invest life in the present with greater significance, value and urgency.

So man's awareness of time as a basic component of his existence may be both integrative and disintegrative in its effects. But even when it is faced with courage and resolution it does not suspend the passage of time or remove the temporal boundaries around the individual life.

(b) Spatiality. The person also occupies a particular and concrete space in the world to which he is attached and to which he belongs. Man's existence is therefore subject to the category of spatiality.⁽²⁾ This space, whether it is a specific bodily space, or the socio-cultural space involved in relationships and places, or the space of a particular physical environment, is a fundamental component of the person's being. Without this space he could not exist:

"Man is an incarnate being, who needs a place and who needs to be attached to it and to be rooted in it."

(Tournier, 1968).⁽³⁾

The person's space, like his time, places boundaries around his

(1) D. Hammarskjöld (Trans. L. Sjöberg and W.H. Auden), Markings (Faber and Faber, 1964), p. 31.

(2) P. Tillich (1951), op.cit., p. 216 f.

(3) P. Tournier (1968), A Place for You (S.C.M., 1968), p. 53.

existence and establishes limits on the existential actualization of his potentialities. This space is constantly under threat and can be disrupted or destroyed. All the familiar spaces on which his being depends, his body, home, family, friendships, occupation, material possessions, social position, political party, race or nation, are finite although they may survive in some sense without him. None is ultimate in itself. Any feature of his unique space, his 'world', may be modified, distorted, or ultimately stripped away resulting in rootlessness and insecurity.⁽¹⁾

These spatial foundations are of vital importance for the person's well-being and security. Anything which threatens any aspect of his particular space constitutes a threat to his being and is yet another expression of the condition of finitude. Against such threats to his space, a person may seek absolute security through aggressive self-assertiveness, authoritarianism, and fanatical adherence to a rigid but dependable system of dogma. Alternatively he may become fragmented and lost in a kind of cosmic diffusion, "the malady of space-time",⁽²⁾ overwhelmed by the experience of spacelessness and rootlessness. Health and illness may then be indicative of a person's appropriation or distortion of his spatiality.

(c) Causality. The person is not self-sufficient and is unable to rest in himself despite all his efforts to do so. A mutual causal interdependence exists between him and his world, and his potential

(1) P. Tournier (1968), *op.cit.*, p. 53. Tournier devotes special attention to the problem of rootlessness and insecurity consequent to the loss of or transformation of a world-view or traditional beliefs and the transformation of the social environment.

(2) *Ibid.*, p. 56 (Cf. de Chardin).

being is bound and limited by forces, drives, and needs beyond his control. This inescapable condition constitutes the category of causality⁽¹⁾ to which the person is subject and upon which his health is contingent:

"Anxiety about fate is the finite being's awareness of being contingent in every respect, of having no ultimate necessity."

(P. Tillich, 1952)⁽²⁾

A person's self-affirmation is subject to internal and external determinants. His experiences of health and illness are contingent upon innate factors, such as autonomic physiochemical processes, inherited physical and psychic resources, sex, and race. It is also contingent upon environmental factors, interpersonal relationships, education, occupation, standards of hygiene and sanitation, nutrition, population density, pollution, medical resources, and countless other factors in his physical and social environment. The contingency of man's existence is a self-evident fact:

"One can show the contingency of the causal interdependence of which one is part, both with respect to the past and to the present, the vicissitudes coming from our world and the hidden forces in the depths of our own self..... Contingently we are put into the whole web of causal relations. Contingently we are determined by them in every moment and thrown out by them in the last moment."

(P. Tillich, 1952).⁽³⁾

In face of such forces a person may well be overwhelmed by hopelessness and surrender his existence in despair, he may become resigned to the

(1) P. Tillich (1951), op.cit., p. 217 ff.

(2) P. Tillich (1952), op.cit., p. 52.

(3) Ibid.

forces which shape his life and accept a passive and nihilistic pattern of life; or, out of his fancies of omnipotence, he may seek to become an absolute cause in himself.

But this is not a simple 'one-way street' in which the person is an inert and helpless object of natural causation, whether exercised by internal or external agents. The person also has the freedom to accept the derivedness and contingency of his being and has the resources to courageously participate in a process of mutual causal interdependence. In this process of continuous adaptation and adjustment, which is vital for his health, the person is shaped by his world and he in turn reshapes his world in a dynamic, dialectical relationship. The person's health is contingent upon this category of his existence, which is characterized by causal interdependence and which can only be escaped by ceasing to be.

(d) Substance. To exist the person also needs form and substance,⁽¹⁾ a substantiality which is psychic and psycho-social as well as physical. Substantial foundations are essential to his existence and give him a concrete form within time and space and within the network of causal relations of which he is part:

"In contrast to causality, substance points to something underlying the flux of appearances, something which is relatively static and self-contained."

(P. Tillich, 1951).⁽²⁾

The person's physical, psychic, and social identity gives him a dynamic centre, a focal point from which his self-affirmation is expressed. This is not far removed from Erikson's concept of identity which, he maintains, is established by its indispensibility in various

(1) P. Tillich (1951), op.cit., p. 219 ff.

(2) Ibid., p. 219.

contexts: (1)

"Psychosocial identity is necessary as the anchoring of man's transient existence in the here and now."

(E. Erikson, 1968).⁽²⁾

Without such foundations the person's being would become diffuse and his potential dissipated.

However, the person's substance is not static, unchangeable, or inviolable. The person's substance is affirmed and maintained under the relative threat of continuous change and distortion and the absolute threat of complete loss of self in death. Both possibilities provoke anxiety:

"This anxiety reaches its most radical form in the anticipation of the final loss of substance - and accidents as well. The human experience of having to die anticipates the complete loss of identity with oneself. Questions about an immortal substance of the soul express the profound anxiety connected with this anticipation."

(P. Tillich, 1951).⁽³⁾

Arising out of such anxiety over the possible loss of substance there is a tendency for the person either to resign his substance in despair or to attempt to make himself into an absolute, unassailable, indestructible substance.

So man's existence is bound by the categories of time, space, causality, and substance, which delineate the boundaries of the unique and integral person as a particular being. But within these categories, the unity and integrity of the whole person is exposed to the perpetual threat of non-being, experienced relatively in division, disruption, distortion, and disease, and absolutely in death. There is no way of

(1) E. Erikson (1968), Identity (Faber & Faber, 1968), p. 42.

(2) Ibid.

(3) P. Tillich (1951), op.cit., p. 219.

escape from these conditions except by ceasing to be. All processes of health then are manifestations of the person's self-affirmation and self-integration, as opposed to self-negation and disintegration, within and in spite of the conditions to which he is subject.

(iv) The Polarities of Existence

As man's being is bound by the categories of time, space, causality, and substance, so too his being involves man in the polarities which are mutually necessary components of his existence. The "self-world structure"⁽¹⁾ is dialectical and ambiguous and is marked by polar qualities which are essential characteristics of human existence. Tillich identifies three outstanding polarities in the self-world structure: individuality and universality, dynamics and form, freedom and destiny.⁽²⁾

(a) Individualization and Participation.

It is in the nature of human existence that each person is both an individual and a participant and his being oscillates between the polarities of individualization and participation, separateness and relatedness, isolation and intimacy, loneliness and inter-personal union. These polarities do not represent either/or alternatives but are both/and necessities: to affirm his being the person is required, by the structure of his existence, to be both a separate, unique individual and a related, responsible participant. This is an inescapable paradox of human existence, as is expressed by R.D. Laing:

".....each and every man is at the same time separate from his fellows and related to them. Such separateness and relatedness are mutually necessary postulates. Personal relatedness can

(1) P. Tillich (1951), Systematic Theology, Vol. I (Nisbet, 1964), p. 183: pp. 186-93.

(2) Ibid., p. 183.

exist only between beings who are separate but who are not isolates. We are not isolates and we are not parts of the same physical body. Here we have the paradox, the potentially tragic paradox, that our relatedness to others is an essential aspect of our being, as is our separateness, but any particular person is not a necessary part of our being."⁽¹⁾

The potentially tragic character of this polarity lies in the possible loss of self, that is the possibility of ceasing to be, which is present at either extreme. The possibility of complete isolation and of absolute separation is inherent in the process of individualization. This prospect is intolerable and provokes anxiety which drives the individual to participate and to seek interpersonal union.⁽²⁾ But, having moved into the realm of relatedness and participation, the individual is faced with the no less threatening possibility of being totally absorbed in intimacy and of being swallowed up in the collective. Then, driven by the anxiety which this potential loss of self arouses, the person moves away from participation to reaffirm his uniqueness as a differentiated individual.

An attempt may be made to resolve this polar tension either by denying one's individuality in a habitual and compulsive movement toward intimacy and collectivism or by a flight from participation in aggressive self-assertiveness and extreme individualism. In either case and whatever the means of escape the effects are equally self-negating and eventually self-destructive.

(1) R.D. Laing (1960), op.cit., p. 26.

(2) In his discussion of the nature of love, E. Fromm argues that man's deepest need is to overcome his separateness, to leave the prison of his aloneness, and to engage in interpersonal union. The driving force behind this movement is the anxiety of separation, and absolute failure to achieve this aim means insanity. The Art of Loving, (Allen & Unwin, 1964), p. 13-14.

The paradox is that both individualization and participation, both the movement toward and the movement away from others, are necessary to the person's health and self-affirmation⁽¹⁾: "Through participation with others a man finds himself, but it is only as he finds himself that he is able to participate" (Macnab, 1965).⁽²⁾ The appropriation or distortion of this polarity is central to man's discovery of himself and to his health.

(b) Form and Dynamics.

Another fundamental component of the self-world structure is the polarity between form and dynamics⁽³⁾ which is "expressed in the fact that in order to be, man must have form, but this form, not sufficient in itself, always reaches out beyond itself" (F.A. Macnab, 1965).⁽⁴⁾ This polarity is experienced in the tension between integration and expansion, homeostasis and dynamic adjustment, self-identity and self-creation.

Like the polarity between individualization and participation, the polarity of form and dynamics is also vital to man's well-being. To exist, the person needs form and relatively stable and secure substance. But a form without dynamics becomes static and its potentiality stifled. Therefore, the person also needs the quality of dynamics in order to adjust to external changes and to fulfil the potentiality inherent in

(1) In Fromm's view the basic or primary flow is from separateness towards relatedness. But existentially it seems that both movements are vital to health. In some circumstances the ability to tolerate and to come to terms with a measure of aloneness and solitude is necessary to a person's well-being. Cf. A. Storr, *op.cit.*, p. 38.

(2) F.A. Macnab (1965), *op.cit.*, p. 156.

(3) P. Tillich (1951), *op.cit.*, p. 197 ff.

(4) F.A. Macnab (1965), *op.cit.*, p. 156.

his form. But dynamics without form can lead to diffusion and chaotic formlessness in which the person's potentiality is dispersed. Here is another potentially tragic paradox of human existence. The possibility of non-being is present at both poles: either in the desperate preservation of one's form and the consequent loss of dynamics or in the diffusion and formlessness of uncontrolled dynamics and the consequent loss of a personal centre.

Form is expressed in man's experience as self-conservation and dynamics appear in man's capacity for self-transcendence and facility for creating new forms.⁽¹⁾ Both are essential to the affirmation of the unique person as an integral whole.

(c) Freedom and Destiny.

The third polarity which constitutes a fundamental component of the self-world structure is that of freedom and destiny,⁽²⁾ which is experienced in the tension between freedom and responsibility, autonomy and accountability, intentionality and necessity, independence and dependence.

"Man is man because he has freedom, but he has freedom only in polar interdependence with destiny.Man experiences the structure of the individual as the bearer of freedom within the larger structures to which the individual structure belongs. Destiny points to this situation in which man finds himself, facing the world to which, at the same time, he belongs".

(P. Tillich, 1951).⁽³⁾

(1) P. Tillich (1951), op.cit., p. 200-1.

(2) Ibid., p. 201 ff.

(3) Ibid., p. 202.

Freedom appears in man's capacity to deliberate, to decide, and to choose, and is expressed in fact that "Man does not simply exist but always decides what his existence will be, what he will become in the next moment" (V. Frankl, 1959).⁽¹⁾ But this capacity for freedom is not absolute or infinite. Man only has this freedom and facility for self-transcendence within the larger structures of existence which comprise his destiny. Without his destiny he could have no freedom, but without freedom he could not answer to or fulfil his destiny. They are correlative.

The relevance of the polarity between freedom and destiny in the realm of health is conveyed by Gotthard Booth:

"Health means not only what man demands from the world, but also what the world demands of man";⁽²⁾

and also by V. Frankl in his consideration of the meaning of life:

"Ultimately, man should not ask what the meaning of life is, but rather he must recognize it is he who is asked. In a word, each man is questioned by life; and he can only answer to life by answering for his own life; to life he can only respond by being responsible."⁽³⁾

Man's destiny lies in the basic structures of his existence and in the questions which life asks of him, and his freedom resides in his answerability to life and in his capacity to fulfil his destiny responsibly. But, tragically, a man may surrender his freedom through a sense of helplessness in face of fate and give up his existence by succumbing to the necessity and determinacy of his destiny, or he may seek to preserve his freedom through a sense of omnipotence and forfeit

(1) V. Frankl (1959), Man's Search for Meaning (Hodder & Stoughton, 1964), p. 132.

(2) G. Booth in P.B. Maves (ed.), *op.cit.*, p. 13.

(3) V. Frankl, *ibid.*, p. 111.

his existence by defying his destiny and by evading his responsibility and accountability. Both are potentially tragic possibilities, for, in its very nature, human life is both patterned and purposive, determined and free.

None of these polarities can be escaped except by ceasing to be and in each case man is confronted with the existential dilemma of achieving a positive and creative balance between these fundamental polarities. In seeking to achieve this vital balance man is open to possibilities of both health and illness, integration and disintegration, self-affirmation and self-destruction.

(v) Anxiety and the Threat of Non-Being

Possibilities of disease, disintegration, and death are ever-present in the categories and polarities of human existence. Within these conditions, anxiety is an existential phenomenon which is always present as man's awareness of his finitude, as "the state in which a being is aware of its possible non-being" (P. Tillich, 1952).⁽¹⁾ Anxiety is the inevitable consequence of the all-pervading threat of ceasing to exist to which man is exposed and of which he is aware and it is therefore existential and cannot be removed. Under the conditions of existence, a life free from stress, tension, and anxiety is inconceivable and is "an idle dream".⁽²⁾

Anxiety, in this view, is man's apprehension of and response to anything which, in his perception, constitutes a threat to any aspect of his being. It is the warning signal of potential or actual disintegration in any sphere of the person's existence. Behind existential anxiety lies the condition of finitude and the threat

(1) P. Tillich (1952), op.cit., p. 44.

(2) R. Dubos, op.cit., p. 221.

of non-being: (1)

"Anxiety is finitude, experienced as one's own finitude. This is the natural anxiety of man as man, and in some ways of all living beings. It is the anxiety of non-being, the awareness of one's finitude as finitude" (P. Tillich, 1952). (2)

Anxiety, understood in this way, is of fundamental importance in man's attempts to achieve an authentic existence and it is, in a sense, the fulcrum on which all experiences of health and illness balance.

Tillich's argument is that anxiety is a natural and necessary aspect of man's life. Anxiety is existential and "belongs to existence as such and not to an abnormal state of mind as in neurotic (or psychotic) anxiety" (P. Tillich, 1952). (3) He then distinguishes three types of

- (1) S. Hiltner and K. Menninger (eds.), Constructive Aspects of Anxiety (Abingdon, 1963), provide a valuable consideration of the main theories of anxiety formulated by both psychologists and theologians. The concept of anxiety as man's response to anything which threatens his existence is implicit to many of these. For instance, with reference to Freud, they observe: "Symptoms are created to avoid the outer or inner danger situation of which anxiety sounds the alarm" (Ibid., p. 8). When the danger is sensed and a signal given so that the organism may act or react to that danger then the constructive function of anxiety is being performed (Ibid., p. 35). If the adaptive behaviour in response to anxiety is appropriate and effective then the threat is allayed and the anxiety is dissipated (Ibid., p. 38). However, it often happens that anxiety produces symptoms and mal-adaptation, which takes pathological forms (Ibid., p. 37 f). Hence, anxiety may be both constructive and destructive in its effects.

A similar view is expressed by R. May: "Anxiety is the apprehension cued off by a threat to some value which the individual holds essential to his existence as a personality" (Ibid., p. 49). In any case, it is the threat of non-existence inherent in human existence which lies at the root of all anxiety.

- (2) P. Tillich (1952), op.cit., p. 44.

- (3) Ibid., p. 49. In S. Hiltner & K. Menninger, op.cit., p. 135, P.W. Pruyser asks "What, in experiential terms, is this so-called existential anxiety?" It is, he suggests, man's awareness and anticipation of a terminus which is felt centrally, demonstrated psychosomatically, experienced unpleasantly, and reacted to holistically. H.S. Sullivan (1954, b), op.cit., p. 378, also observes that "we are never unaware of anxiety at the very time that it occurs...one is always at least momentarily aware that one

anxiety "according to the three directions in which non-being threatens being" (Ibid.).⁽¹⁾

(a) The most basic type of anxiety is that which arises out of man's awareness of that which threatens man's ontic self-affirmation, that is which threatens "the basic self-affirmation of a being in its simple existence" (Ibid.).⁽²⁾ Anything which invades or jeopardises the biological and physical foundations of man's being, anything which threatens man's form and substance, provokes the anxiety of fate and death:

"The anxiety of fate and death is the most basic, most universal, and inescapable. All attempts to argue it away are futile.existentially everybody is aware of the complete loss of self which biological extinction implies." (Ibid.).⁽³⁾

Man is aware of the contingency and transitoriness of his life and of the relative threat of fate, disease, injury and disintegration and of the absolute threat of death. The consequent anxiety may drive him to desperate attempts to preserve his substance, or he may be driven to the "boundary-line" of despair and seek to escape by suicide, the ultimate in self-negation,⁽⁴⁾ or he may courageously affirm his being in spite of the anxiety of fate and death.

(b) Man's spiritual self-affirmation, that is man's capacity to live "creatively in the various contexts of meaning" (Ibid.),⁽⁵⁾ is under the threat of destruction which becomes manifest relatively in

has become uncomfortable, or more acutely uncomfortable, as the case may be". Whatever the cause, the symptoms, and the consequent effects, there is always the awareness of such anxiety.

(1) Ibid., p. 49.

(2) Ibid., p. 50.

(3) Ibid.

(4) Ibid., p. 61-2.

(5) Ibid., p. 53.

emptiness and absolutely in meaninglessness.⁽¹⁾ Threats to his spiritual affirmation, anything which undermines his capacity to live creatively and meaningfully, is also a source of natural anxiety.

Man is both a creator and a creature. As a creator he is anxious to create, to shape, and to realize his potentiality meaningfully and purposefully. But as a creature he is anxious about the contingencies which limit his spiritual freedom and creative potential:

"Man's being includes his relation to meanings. He is human only by understanding and shaping reality, both his world and himself, according to meanings and values. ...Therefore the threat to his spiritual being is a threat to his whole being. The most revealing expression of this fact is the desire to throw away one's ontic existence rather than stand the despair of emptiness and meaninglessness." (Ibid.)⁽²⁾

Deprived of meaning and values man may fall into a nihilistic life of compromise and expediency in the interests of survival, or in despair may take the ultimate flight from life,⁽³⁾ or he may seek security in a rigid and authoritarian system of dogma to which he holds with fanatical self-assertiveness.⁽⁴⁾ The only alternative is to courageously

(1) P. Tillich (1952), op.cit., p. 53. In the theories of C.G. Jung the loss or breakdown of a basic framework of meaning constitutes the major threat to man's well-being in the modern world. This is the basic theme of Modern Man in Search of a Soul (1934), op. cit., in which he states: "When conscious life has lost its meaning and promise, it is as though a panic had broken loose and we heard the exclamation: 'Let us eat and drink, for tomorrow we die!'" (Ibid., p. 269). Not only does meaninglessness give way to nihilistic hedonism, it also lies behind psychoneurosis (Ibid., p. 261). The same conviction is implicit in V. Frankl's concept of present day nihilism as an "existential vacuum" devoid of meaning (1959, op.cit., p. 108 ff.).

(2) Ibid., p. 58.

(3) Ibid. The wish for death, ultimately expressed in suicide, as a flight from despair is then a spiritual phenomenon.

(4) Ibid., p. 57.

accept doubt and insecurity and to seek the spiritual content in his existence in spite of threats of emptiness and meaninglessness.

(c) Anxiety also arises out of threats to man's moral self-affirmation which appear relatively in guilt and absolutely in condemnation. Man's being is moral, as well as ontic and spiritual, and involves an element of responsibility and accountability. Man's being "is not only given to him but is also demanded of him. He is responsible for it: literally, he is required to answer, if he is asked, what he has made of himself" (Ibid.).⁽¹⁾ And man is asked to account for his existence. He asks the question of himself according to the values and goals which he sets for himself.

But man's moral self-affirmation, which contributes to the fulfillment of his destiny and to the actualization of what he potentially is, is always threatened. There is always a contrast between existential actualities and essential possibilities, between what one is and what one could become, which lies at the root of man's estrangement and guilt. This may be a healthy tension⁽²⁾ but there is the danger of being driven to an extreme sense of condemnation:

"The anxiety of guilt.....is present in every moment of moral self-awareness and this can drive us toward complete self-rejection, to the feeling of being condemned - not to an external punishment but to the despair of having lost our destiny" (Ibid.)⁽³⁾

Anxiety, in this view, whether it is provoked by threats to man's ontic, spiritual, or moral self-affirmation, is an inescapable and irremovable aspect of human existence. This means that, in essence,

(1) P. Tillich (1952), p. 58.

(2) Cf. V. Frankl (1959), op.cit., p. 106.

(3) P. Tillich, ibid., p. 59.

anxiety is neither healthy or pathological in nature. In the life of a man it may be both integrative and disintegrative in its effects, and both healthy and unhealthy manifestations of anxiety may be ambiguously mixed in the totality of the person's living experience.

Tillich distinguishes between existential and pathological anxiety⁽¹⁾ but this distinction is quantitative rather than qualitative. The difference is simply conveyed in H.S. Sullivan's contrast between "coming to grips with" anxiety and "being in the grip of" anxiety.⁽²⁾ The difference is then not to be found in the nature of anxiety itself, as an existential phenomenon, but in the individual person's appropriation or distortion of anxiety.

When man courageously transcends the conditions and polarities of his existence and "comes to grips with" his anxiety, then anxiety may become a dynamic and constructive ally in the processes of self-affirmation and healing. From a biological point of view, fear and anxiety may be understood as "guardians" which sound the alarm of potential or actual threats to man's being and which produce the movements toward resistance and preservation which are necessary to adaptation and health.⁽³⁾ Anxiety may provide the dynamic forward-intention which leads to the fulfilment of man's ontic, spiritual, and moral self-affirmation. It has been argued furthermore, that in a therapeutic context anxiety provides a clue to prognosis as an indication that "the person is motivated in the direction of recovery" and may

(1) P. Tillich (1952), op.cit., pp. 69-81.

(2) H.S. Sullivan (1954 (b)), op.cit., p. 301.

(3) P. Tillich, *ibid.*, p. 81-2.

be a constructive ally in the healing process.⁽¹⁾

In this view, anxiety is not only irremovable, it is a desirable and necessary aspect of man's being and plays a vital part in man's self-affirmation and health. With the courage which is given to him man can come to terms with anxiety in such a way that it fulfils its constructive functions. But even this courage does not eliminate anxiety:

"Courage does not remove anxiety. Since anxiety is existential, it cannot be removed. But courage takes the anxiety of non-being into itself. Courage is self-affirmation "in spite of" namely in spite of non-being". (Ibid.)⁽²⁾

This view of anxiety and its function in human life is diametrically opposed to the notion that homeostasis, a balanced and harmonious equilibrium, is a universal and essential characteristic of health in all its aspects.⁽³⁾ While self-regulation, orderliness, and homeostasis

- (1) For example see W.E. Oates (1955), *op.cit.*, p. 14 (Cf. A. Boisson), who goes on to argue that anxiety is correlative to freedom and is essential to the healing process (*Ibid.*, p. 222 ff). An equally positive evaluation of the function of anxiety and "anxious longing" is presented by F. Berthold in S. Hiltner & K. Menninger, *op.cit.*, pp. 69-80. Also see O.H. Mowrer, *op.cit.*, pp. 26, 33. Also V. Frankl, *op.cit.*, pp. 125-131, where he presents his concept of "paradoxical intention" in which the positive use of anxiety is implied, as a valuable therapeutic procedure.
- (2) P. Tillich (1952), *op.cit.*, p. 70-1.
- (3) The principle of homeostasis is a fundamental biological law: see I.G. Barbour, *op.cit.*, p. 318-19, and also R. Dubos and M. Pines, *op.cit.*, pp. 11-16. While it may be applicable in the organic and biological realm of man's being, this biological law cannot be automatically transferred to other realms of man's being. This is the essence of reductionism: that is, the deduction of theories or laws in one area of inquiry from theories or laws formulated in another area (Cf. I.G. Barbour, *op.cit.*, p. 325-6). Man is not simply an organism, but unfortunately the biological law of homeostasis is not infrequently universalized to apply to the totality of man's experience, as is done, for example, in the Freudian "pain and pleasure principle".

are vital with respect to a person's biological affirmation, it is an inescapable paradox that adaptation, tension, and anxiety are no less crucial for the person's well-being. Although it is invariably unpleasant, anxiety represents a necessary and healthy tension, a healthy discontent. This conviction is implicit in Frankl's concept of "noo-dynamics":⁽¹⁾

"Man's search for meaning and values may arouse inner tension rather than inner equilibrium. However, precisely such tension is an indisputable prerequisite of mental health":⁽²⁾

and this view is echoed by Rene Dubos:

"Harmonious equilibrium with nature is an abstract concept with a Platonic beauty but lacking the flesh and blood of life. It fails, in particular, to convey the creative emergent quality of human life."⁽³⁾

Indeed, in Tillich's view, to try to remove all anxiety and to seek complete freedom from this state of inner tension is not only futile but may also be pathological because it destroys man's basic nature.⁽⁴⁾

(1) V. Frankl, *op.cit.*, p. 105 ff.

(2) *Ibid.*, p. 105.

(3) R. Dubos, *op.cit.*, p. 31.

(4) P. Tillich (1952), *op.cit.*, pp. 75-81, is particularly critical of the assumption, not uncommon in psychotherapy and psychoanalysis, that all forms of anxiety are pathological and that anxiety constitutes a "sickness" which can and must be healed. This assumption "includes a decision about the nature of man" (*Ibid.*, p. 75) which must be exposed. In effect, attempts to achieve complete perfection, absolute homeostasis, and complete freedom from anxiety are demonic because they destroy man's basic nature. As he states elsewhere: "psychotherapy of the mechanistic type tries to transform men into well-functioning homomuncili or artificial men. But none of them works permanently; on every level freedom breaks through managed perfection" (quoted by W. Oates (1955), *op.cit.*, p. 223; from "Human nature can change: a symposium," *American Journal of Psychoanalysis*, 1952, xii).

This is not to say that anxiety is healthy in all circumstances, any more than it can be claimed that all anxiety is pathological. Anxiety can be destructive and can produce symptoms and non-adaptive behaviour when it takes possession of a person's being, and its effects may be evident in physical, intrapersonal, interpersonal, and spiritual processes of disintegration. The intensity of anxiety may be out of all proportion to the threat by which it is provoked and its grip may be so profound that it becomes destructive rather than creative, disintegrative rather than integrative: "The power of non-being becomes so prevailing that man is unable to affirm himself or find any affirmation of his being" (F.A. Macnab, 1965)⁽¹⁾. Pathological anxiety is that in which helplessness, futility, and despair have taken over to the extent that it interferes with effectiveness in living, restricts the achievements of desired goals and satisfactions, and stifles the person's self-affirmation.

Such overwhelming "free-floating" anxiety may be physically destructive rather than protective.⁽²⁾ Under conditions which provoke anxiety and stress, emergency operations of the autonomic nervous system, self-regulating physicochemical processes, are called into effect to prepare the organism for "fight" or "flight".⁽³⁾ The built-up tension and energy is normally expended in appropriate action. In an "anxiety state", however, the human organism is prepared for action but usually ends by doing little or nothing and these physicochemical processes are maintained at an abnormally high and potentially dangerous level.

(1) F.A. Macnab (1965), *op.cit.*, p. 155.

(2) P. Tillich (1952), *op.cit.*, p. 83.

(3) See R. Dubos and M. Pines, *op.cit.*, pp. 11-12, 145-151 (Cf. W.B. Cannon, 1915); and M. Hamilton, *op.cit.*, pp. 12-23.

The effects may be disastrous.⁽¹⁾ When despair and dread have taken over, the destructiveness may appear in physiological disintegration, in feelings of futility, defeat, condemnation and meaninglessness, and in drives toward suicide and self-destruction.

Anxiety and the drive to avoid despair may also lead to psychic disintegration. A person may seek to eradicate anxiety by escaping into neurotic defense-mechanisms and security operations.⁽²⁾ As Tillich suggests, "He who does not succeed in taking his anxiety courageously upon himself can succeed in avoiding the extreme situation of despair by escaping in neurosis".⁽³⁾ The neurotic way of combating anxiety is to construct defences which diminish or repress anxiety. But these defences are unrealistic and self-reducing:

"Neurosis is the way of avoiding non-being by avoiding being. In the neurotic state self-affirmation is not lacking; it can indeed be very strong and emphasized. But the self which is affirmed is a reduced one. ...He affirms something which is less than his essential or potential being. He surrenders a part of his potentialities in order to save what is left."

(P. Tillich, 1952).⁽⁴⁾

The neurotic person builds "a narrow castle of certitude which can be

- (1) The concept of the "fight or flight response" was postulated by W.B. Cannon in 1915 (see R. Dubos & M. Pines, *op.cit.*, p. 148). But if no action follows stimulation and preparation for "fight or flight" the effects may be physically destructive. For example, Dubos and Pines, *ibid.*, p. 149, describe a Russian experiment with chimpanzees in which a male was physically but not visually separated from his mates, then another male was given access to his mates. The deprived male was dead within three months from arteriosclerosis and hypertension induced by violent and helpless rage and jealousy. Dubos and Pines observe that in the conditions of urban civilization man is in a similar position in which "it is virtually impossible to relieve tensions by taking physical action". (*Ibid.*)
- (2) See H.S. Sullivan (1954 (b)), *op.cit.*, pp. 351-359.
- (3) P. Tillich (1952), *op.cit.*, p. 71.
- (4) *Ibid.*

defended and is defended with the utmost tenacity" (Ibid.).⁽¹⁾ and may assert his limited self vigorously and compulsively. But the end result can only be stagnation, sterility, and breakdown. No matter how vigorously his 'castle' is defended, his neurotic refuge is never absolutely impregnable or indestructible and freedom and anxiety may break through at any point. The tragic paradox is that in seeking to defend and preserve himself the neurotic is driven to destroy himself.

Anxiety, which has its roots in man's awareness of estrangement and finitude as basic conditions of human existence, is a central component and a dynamic force in all processes of health and illness. When it is courageously confronted anxiety can be a dynamic, constructive, and integrative force which contributes to man's self-affirmation. But it can also be a stifling, crippling, and destructive force when it takes possession of a man's being and he is driven into a neurotic, limited mode of self-affirmation or gives way to unlimited despair.

LIFE PROCESSES AND DIMENSIONS OF BEING

The affirmation and unity of the person as an integral whole is the primary characteristic of health. But under the conditions of existence, being subject to the categories of existence and being involved in its polarities, this unity is never complete and is open to attack from many directions. As is implied in the phrase "the multidimensional unity of life", the unity of the person is not monolithic. The person's being-in-the-world has many dimensions and involves a variety of processes, "life processes"⁽²⁾, which are constitutive for life:

"In finitude and estrangement man is not a whole, but is disrupted into different elements. Each of these elements can disintegrate independently of the other elements. Part

(1) P. Tillich (1952), op.cit., p. 80.

(2) P. Tillich (1963), op.cit., p. 34.

of the body can become sick, without producing mental illness; and the mind can become sick without visible bodily failures. In some forms of mental illness, especially neurosis, and in all forms of bodily disease the spiritual life can remain completely and even gain in strength".

(P. Tillich, 1957 (b)).⁽¹⁾

These dimensions of the person's being are not absolutely independent, neither are they absolutely dependent, and in the dynamics of the different dimensions processes of health and illness are ambiguously mixed together in the total experience of the person.⁽²⁾ No single-cause theory can account for all manifestations of disease and disintegration:

"There are many processes of disintegration leading to disease, and there are many ways of healing, of trying to reintegrate, and many kinds of healers, depending on the different processes of disintegration and the different ways of healing".

(P. Tillich, 1963).⁽³⁾

In the ambiguity of life, disease may occur in one element and not in others, disintegration in one realm may affect or infect other realms, disease in one dimension may enhance health in another, and health in one area may increase disease in another.⁽⁴⁾ Within the total experience of the person, each dimension is capable of both acting independently and of interacting with each of the other dimensions, and in this continual interplay no absolute divisions can be established between the elements which comprise the whole person.

What then is required is a multilateral approach to the study of

(1) P. Tillich (1957 (b)), op.cit., p. 14.

(2) P. Tillich (1963), op.cit., p. 296.

(3) Ibid., p. 295.

(4) Ibid., p. 300.

health and the adoption of interdisciplinary procedures in healing methods. Conflict between different ways of healing is inevitable only if any one method claims exclusive validity or imperialistic primacy. In some circumstances several methods should be used together and in other circumstances one method alone will be most appropriate.⁽¹⁾ This is an eclectic viewpoint, but is necessitated by the ambiguous nature of health and illness within the multidimensional unity of the whole person.

Tillich distinguishes three primary functions of life, or life processes, which are constitutive for life and health.⁽²⁾ Each process unites elements of self-identity with elements of self-alteration, and the polar tension between integration and alteration may be a source of disruption in the person's experience:

"The three functions of life unite elements of self-integration with elements of self-alteration. But this unity is threatened by existential estrangement, which drives life in one or the other direction, thus disrupting the unity".

(P. Tillich, 1963).⁽³⁾

Nevertheless, despite this tension, both integration and alteration are essential to man's health and wholeness and each of the three life processes is vital to man's self-affirmation.

These life processes, as they are manifest in the life of the unique and integrated person, provide a basis for the evaluation of health and illness. The first function of life is that of self-integration, a centred movement of the integrated whole toward self-identity. Then from the basis of a personal centre, the second process

(1) P. Tillich (1963), *op.cit.*, p. 296.

(2) *Ibid.*, pp. 34-113.

(3) *Ibid.*, p. 34.

is a horizontal movement toward self-alteration and self-creation in relation to others and to the world. This process of alteration and adaptation is fundamental to growth as the centred being goes out from identity through alteration and so back to re-establish and reaffirm identity. Then, in contrast to the centred movement of self-integration and the horizontal movement of self-alteration, the third process is a vertical movement toward self-transcendence by which man is driven beyond the finite conditions of existence toward the infinite.⁽¹⁾

(i) Self-Integration and Ontic Self-Affirmation

Health is characterized, in the first place, by self-integration which corresponds with ontic self-affirmation.⁽²⁾ Through the process of self-integration a person affirms his basic existence and actualizes his potential as a unique, differentiated, and separate being in relation to the structured physical and social world to which he belongs. The process of self-integration and individualization expresses itself in "the affirmation of the self as a self; that is, of a separated, self-centred, individualized, incomparable, free, self-determining self" (P. Tillich, 1952)⁽³⁾, a self which cannot be divided or exchanged although it can be destroyed. Self-integration or individualization has both organic and psychic aspects:

Biological affirmation⁽⁴⁾ and successful physiological functioning, as the organic aspect of self-integration, is essential to the person's well-being and is the most obvious index of health. The signs of integration and disintegration in the organic dimension of a person's

(1) P. Tillich (1963), op.cit., p. 33.

(2) Ibid., p. 34 ff., and (1952), op.cit., p. 89 ff.

(3) P. Tillich (1952), op.cit., p. 89.

(4) Ibid., p. 81 ff.

being are less equivocal than in any other realm. Nevertheless, biological affirmation is not entirely free of ambiguity.

Harmonious physiological functioning depends upon maintaining a fixed and balanced internal environment which is orderly, homeostatic, and self-regulating.⁽¹⁾ This is a fundamental biological principle and biological integration provides the concrete structure within which a healthy and free life is possible. But such physiological harmony is never absolute. This state is relative to innate factors, such as heredity, sex, and race, and is relative to age, the durational factor. It is also contingent upon the satisfaction of basic physical needs, such as adequate nutrition, sufficient exercise and relaxation, sexual gratification, satisfactory standards of hygiene and sanitation, for "man stays objectively healthy as long as his individual needs are satisfied" (G. Booth, 1953).⁽²⁾

However, this integrated and harmonious organic state can be attacked and disrupted by internal and external forces, which cannot always be distinguished.⁽³⁾ Under the conditions of existence this delicate physiological balance cannot be sustained ad infinitum. The person, as an organism, cannot rest in himself if he is to survive successfully because biological affirmation involves processes of both self-preservation and self-alteration. In some circumstances a "flight response" is required in the interests of integration, conservation,

(1) The concept of a balanced internal environment as fundamental to biological efficiency was propounded by Claude Bernard, 1865: for further discussion see F.A.E. Crew, *op.cit.*, p. 20 f.; I.G. Barbour, *op.cit.*, p. 318 ff., and R. Dubos and M. Pines, *op.cit.*, p. 11. Also refer to J.L. Smith, Growth (Oliver & Boyd, 1932).

(2) G. Booth in P.B. Maves (ed.), *op.cit.*, p. 3.

(3) J.S. Haldane discusses the difficulty in differentiating between internal and environmental causes in his conclusion to J.L. Smith, *op.cit.*, p. 123.

and self-preservation. But once a person, or a community, rests in himself and ceases to respond to ever-changing environmental circumstances then continued survival is no longer feasible. Therefore, a "fight" response involving adaptation and self-alteration is also necessitated under some circumstances. Then, having adapted, the human organism returns in a centred movement to reaffirm itself.

Nevertheless, an absolutely harmonious balance cannot be sustained indefinitely in the continual flow between integration and alteration. Under the conditions of existence, homeostatic faults are bound to occur in the human organism culminating in disease and ultimately in death. Ageing, it has been suggested, is characterized by "an increase in the number and variety of homeostatic faults".⁽¹⁾ In the process of life and with the passage of time the point is eventually reached, whether gradually or suddenly, when physiological breakdown is irrevocable and organic life can no longer be sustained.

The first and most concrete criterion which can be employed to evaluate health is the degree of biological affirmation and integration manifest in a person's being. The physical basis of life is primary. Health, however, is not simply a matter of organic survival or of physiological efficiency. This is only one dimension of a person's being and health cannot be measured solely in terms of the duration or efficiency of organic life.

Self-integration also has a psychic aspect which is no less crucial for the attainment of health. Psychic self-integration is expressed in self-identity, that is in the establishment of a stable and coherent

(1) R. Dubos and J. H. Allen

differentiated "self".⁽¹⁾ In the context of an integrated and harmonious organic structure, this integrated self, which is unique and distinctive, constitutes the foundation or centre from which life and health are possible and provides the necessary "anchoring of man's transient existence in the here and now" (E. Erikson, 1968).⁽²⁾ Self-identity then is characteristic of health.

The concept of self-integration has many parallels and closely corresponds with the concepts of "identity" (Cf. E. Erikson)⁽³⁾ and of "self-realization" (Cf. A. Storr).⁽⁴⁾ The growth of identity has been described as "a process of increasing differentiation" which occurs in the context of mutual affirmation,⁽⁵⁾ through which a person's unique potentialities emerge and are realized. Increasing differentiation and individualization are the distinguishing marks of self-identity. The same view appears in A. Storr's concept of self-realization as the goal of personal growth:

"I propose to call this final achievement self-realization, by which I mean the fullest possible expression in life of the innate potentialities of the individual, the realization of his own uniqueness as a personality, and I also put forward the

- (1) With reference to the concept of "self", Tillich says: "'Self', in this sense, must not be misunderstood as an object, the existence of which could be discussed, or as part of a living being, but rather as the point to which all contents of awareness are related, in so far as 'I' am aware of them": P. Tillich (1963), *op.cit.*, p. 39.
- (2) E. Erikson (1968), *op.cit.*, p. 42.
- (3) *Ibid.*, and (1950), *op.cit.*, pp. 252-55.
- (4) A. Storr (1960), *op.cit.*, pp. 22-30.
- (5) E. Erikson (1968), *op.cit.*, p. 23.

hypothesis that, consciously or unconsciously, every man is seeking this goal".⁽¹⁾

The integrated self has many characteristics. An integrated person has a healthy enjoyment of physical appetites for food, sex, and play, not simply for their survival value but as sources of pleasure, and seeks the satisfaction of basic needs and pleasures without disgust or remorse. Self-acceptance, as the objective recognition of personal limitations and resources, and stable self-respect are also evident in an integrated self. Another feature is openness to feel and experience a wide variety of emotions and a capacity to express emotions positively. The integrated person is not bound by conformity to a rigid system of oughts or to social conventionalities and is not passively submissive to the expectations of others. The integrated and individuated self is not characterized by slavish dependence on others but is rather autonomous and free as a mindful and intentional source of decisions. That is to say, he is self-aware and self-directed and is responsible for actions carried out on the basis of commitment to realistic and freely established values. The integrated self is also creative and is original in the sense that he originates and utilizes his unique skills and resources constructively. Basically, the integrated self is centred, coherent, independent, and individualized.

While organic and psychic self-integration is constitutive for health, it is one of the ambiguities of life that this process may be disintegrative. Integration implies the possibility of disintegration.

(1) A. Storr (1960), op.cit., p. 27. The same view is expressed by Fromm-Reichmann, op.cit., p. 34, in considering the basic goal of therapy: "By 'self-realization' I mean a person's use of his talents, skills; and powers to his satisfaction within the realm of his own freely established realistic set of values". A further example is to be found in C.R. Rogers, On Becoming A Person (Constable, 1967), p. 167 ff., in which the goal of personal growth is "to be that self which one truly is".

If the process of self-centring and of self-integration is pursued exclusively then it may become self-restrictive rather than self-affirming:

"Disease can also be the consequence of self-restriction of the centred whole, a tendency to maintain self-identity by avoiding the danger of going out to self-alteration.

.....In order to be safe, the organism tries to rest in itself".

(P. Tillich, 1963).⁽¹⁾

In face of internal or external threats, the person may become self-absorbed and turn in on himself in a desperate attempt to secure and preserve his centre. He then settles for a constricted form of affirmation, as in neurosis, and thereby stifles his full potentiality and smothers his individuality. Such excessive self-restriction in the interests of self-conservation may be apparent in an obsessive preoccupation with one's own body and physical well-being, in aggressive self-assertiveness and authoritarianism, in passive submission to others or in conformity to socially acceptable conventionalities, in emotional flatness and detachment, or in a convolitional spiral into depression. Each of these phenomena betrays basic insecurity and the lack of integration. In each case individuality is in fact suppressed or repressed as the person retreats inside himself and becomes his own prison in the attempt to attain absolute security and integration. Whatever form it takes, intensive self-restriction and self-absorption can only be disintegrative in its effects and must be regarded as a fundamental symptom of illness.

Self-integration, therefore, is constitutive for life and health; but it is so in a perpetual dialectical relationship with the process of self-alteration..

(1) P. Tillich (1963), op.cit., p. 37.

(ii) Self-Creativity and Moral Self-Affirmation

In order to affirm his being and to realize his potential a person must move out from his integrated centre to participate in the physical and social world of which he is part and in which he takes part. Indeed, integration cannot be achieved or maintained without such participation. The second process, therefore, which is constitutive for health is self-alteration or self-creativity which corresponds with Tillich's concept of moral self-affirmation.⁽¹⁾ Self-creativity is expressed in the capacity to form durable and mature interpersonal relationships, in a facility to engage in intimacy, and in a willingness to participate in the world in a positive and responsible manner.

To be healthy the individual person needs to move out beyond himself to establish secure interpersonal and social foundations.⁽²⁾ The satisfaction of needs for intimacy, dependence and interdependence, affection, and for the acceptance and respect of others is fundamental to health, and a capacity to engage in mature and intimate relationships is therefore one of the hallmarks of health:

"Only in the continuous encounter with other persons does the person become and remain a person. The place of this encounter is the community". (P. Tillich, 1952).⁽³⁾;

or as expressed by Anthony Storr,

"Self-realization is not an anti-social principle; it is firmly based on the fact that men need each other in order to be

(1) P. Tillich (1963), op.cit., p. 53 ff.; and (1952).

(2) For discussions of the concept see R.A. Lambert.

(3) P. Tillich (1952) op.cit., p. 93.

themselves, and that those people who succeed in achieving the greatest degree of independence and maturity are also those who have the most satisfactory relationships with others".⁽¹⁾

The absolute failure to enter into interpersonal union and to establish secure social foundations can only lead to greater separation and estrangement and is eventually destructive, either self-destructive or destructive of others.⁽²⁾ Man would become insane, in Erich Fromm's view, if he could not liberate himself from the prison of his separateness and aloneness and "unite himself in some form or other with men, with the world outside".⁽³⁾

The capacity to engage in interpersonal union has been described as "mature love" (Cf. Fromm)⁽⁴⁾ or "mature dependence" (Cf. Storr)⁽⁵⁾. Mature dependence is apparent in co-operative relationships in which there is evenly matched giving and taking between two differentiated individuals who are mutually dependent, in which there is an absence of primary identification and incorporation, and in which there is no evidence of attempts by one participant to dominate the other or to be absorbed by the other.⁽⁶⁾ Such relationships are marked by mutual care, respect, responsibility and knowledge.⁽⁷⁾ The key to such relationships, according to A. Storr, is personal appreciation and acceptance of the other; acceptance in the sense of profound personal appreciation, in the sense of recognizing the difference of the other from oneself

(1) A. Storr (1960), *op.cit.*, p. 32.

(2) Cf. E. Fromm (1964), *op.cit.*, p. 20.

(3) *Ibid.*, p. 13.

(4) *Ibid.*, p. 21.

(5) A. Storr (1960), *op.cit.*, p. 32.

(6) *Ibid.*, p. 41.

(7) Cf. E. Fromm (1964), *op.cit.*

and in respecting that difference: (1)

"It seems probable that this irrational acceptance, this sense of being loved as a whole without reservation is the basis of adult confidence in oneself as a person, and also of satisfying relationships with others; and that neurotic disharmony occurs as a result of real or imagined lack of acceptance" (A. Storr, 1960). (2)

Although processes of self-integration and self-alteration, individualization and participation, may be in tension at many points in the person's living experience, they are in fact mutually necessary and are held together in a dialectical relationship. Identity and intimacy are reciprocal. Self-identity and self-respect can only develop in the contexts of interpersonal relatedness and through mutual affirmation (3); but it is only out of secure self-identity that one is able to give oneself to another and to participate in intimacy with even greater potency. (4) This inescapable existential paradox is expressed in the Biblical injunction: "Love your neighbour as yourself!" (5) Self-love and love of others are correlative.

The irony, as Storr has observed, is that those who are unable to enter into satisfying and intimate relationships with others do not become more individual; they tend rather to become more alike and lacking in a distinctive personal identity:

"In the absence of relationship with others, men become more alike, not more individual; and isolation leads ultimately to a loss of distinguishing features of personality, not, as might be supposed, to their intensification.

(1) A. Storr (1960), *op.cit.*, p. 41 f., 73 f. Also see C.G. Jung (1934), *op.cit.*, p. 270 f.

(2) *Ibid.*, p. 74.

(3) E. Erikson (1968), *op.cit.*, p. 21-4.

(4) E. Fromm (1964), *op.cit.*, p. 23.

(5) Leviticus 19: 18, 34; Matthew 19: 19; 22: 39; Romans 13: 9.

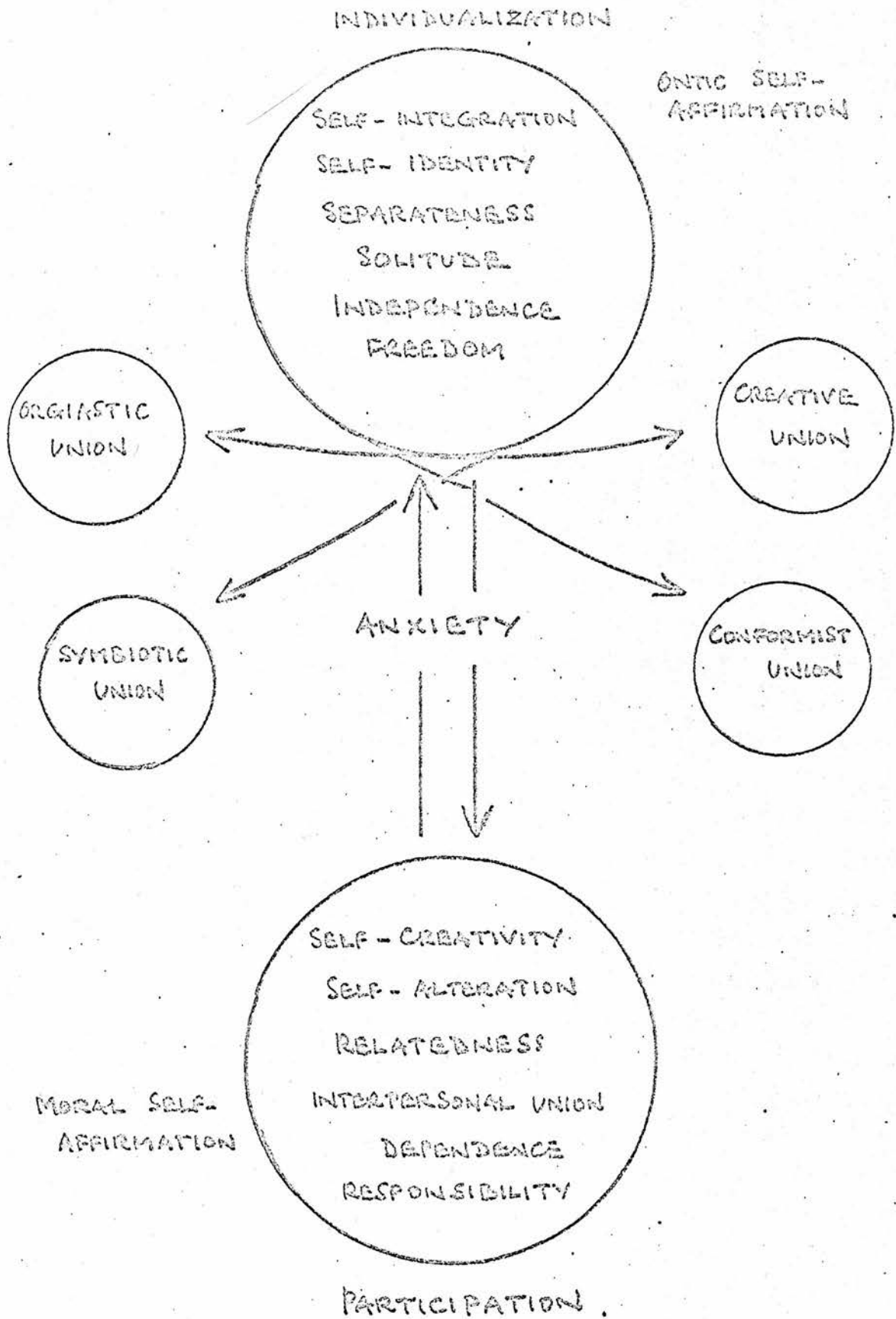
.....So we have the paradox that man is at his most individual when most in contact with his fellows, and is least of all a separate individual when detached from them."⁽¹⁾

A measure of solitude is probably healthy and stimulating in some circumstances and contributes to the development of the personality,⁽²⁾ and an ability to tolerate a degree of isolation and separation is necessary for health. But a state of absolute separation cannot be endured and can only lead to emotional starvation and mental disintegration. The existential paradox is that under conditions of complete estrangement there is a loss of individuality and a trend toward collective conformity, uniformity and stereotypy.

The paradox is that both self-integration and self-alteration are constitutive for health but there are dangers inherent in both processes. Self-integration implies the possibility of disintegration, and so too self-creativity implies the possibility of destruction. An attempted conceptualization of the polarity between individualization and participation is presented in Figure I (over). In seeking to achieve ontic self-affirmation through self-integration and individualization, a person is exposed to the possibility of becoming absolutely self-absorbed and completely isolated, which is an intolerable prospect. Then, driven by the anxiety which this threat provokes, he moves out from his self-centred individuality to seek interpersonal union and to achieve moral self-affirmation through participation. But participation also exposes him to threats to his existence as a unique individual. At this pole he encounters the possibility of being completely overwhelmed and absorbed by others in total interpersonal fusion. This potential loss of self in fusion with others arouses anxiety which drives him back into

(1) A. Storr (1960), *op.cit.*, p. 35.

FIGURE I : THE POLARITY OF INDIVIDUALIZATION & PARTICIPATION.



himself to re-establish his centre and to reaffirm his individuality and independence.

This polarity and the consequent anxiety are existential, that is they are inherent in the conditions of human life, and cannot be absolutely resolved and can never be escaped except by ceasing to be. Man needs to achieve a balanced flow between individualization and participation, isolation and intimacy, freedom and responsibility, independence and dependence, if he is to affirm his potential and to achieve health. If one process, either self-alteration or self-integration, becomes the predominant or exclusive driving-force in a person's life it can only result in disintegration and destruction through "self-deification" and individualistic self-assertiveness or "group-deification" and conformist communalism.⁽¹⁾

While some writers regard the movement from isolation and separateness toward relatedness and interpersonal union as being primary,⁽²⁾ there is no doubt that self-creativity and participation may become destructive and may lead to the loss of a personal centre if it is pursued exclusively. Erich Fromm, in his analysis of love, suggests that man sometimes engages in forms of union which provide only partial or destructive solutions to his fundamental need to overcome his separateness and which are inadequate substitutes for interpersonal union (see Figure I).

In a desperate attempt to overcome the anxiety engendered by separateness, man may engage in "orgiastic union" which is intense, even violent, involves the whole personality, and is temporary and

(1) D.E. Roberts in P.B. Mayes (ed.), op.cit., p. 283.

(2) For example, E. Fromm (1964), op.cit., p. 13-14; R.A. Leary (1963), op.cit., p. vii, p. 90 ff.; D.E. Roberts op.cit., p. 25; Fromm-Reichmann (1963) that interpersonal human life.

spasmodic.⁽¹⁾ Although orgiastic union may temporarily alleviate anxiety it is intrinsically shallow, transitory, and selfish, and can only end in an intensified sense of isolation and increasing desperation to achieve union.

The most common solution is apparent in the union achieved through collectivization, "conformist union", through conformity with the customs, beliefs, and practices of the group or herd.⁽²⁾ By contrast with orgiastic union, conformist union is calm, dictated by routine, and more permanent. But collectivism is insufficient to pacify the anxiety of separateness. In herd conformity, the individual is absorbed by the group, differences are eliminated, and equality becomes sameness. The implied loss of self arouses anxiety once again.

Another partial solution to the dilemma of separation is evident in the union which occurs in "creative activity".⁽³⁾ In creative work, the creator becomes one with his creation and identifies himself with it. But union achieved through creativity may become so expansive, manifold, and abundant that the creator's individuality and his capacity to engage in interpersonal union are lost in diffusion.

A fourth and particularly destructive form of union is evident in "symbiotic union",⁽⁴⁾ which has its model in the union of the foetus and the pregnant mother, a union in which one is totally absorbed by another. This kind of union is evident in sado-masochistic relationships, in which one is compliant, passive, and submissive in relation to the dominance, power, and authority of another. It may also appear in self-

(1) E. Fromm (1964), *op.cit.*, p. 15f.

(2) *Ibid.*, p. 16 f.

(3) *Ibid.*, p. 19 f.

(4) *Ibid.*, p. 20 f.

abrogating and self-abnegating submission to a mystical supreme being. Such total self-surrender and self-denial, in compliance with the supposed will of a supreme being, is not uncommonly regarded as a Christian virtue. But the healthiness of such a notion is extremely dubious.⁽¹⁾

In their extreme forms, each of these processes implies the loss of self and each involves the destruction of self or the destruction of others. Such distortions of interpersonal union can only be regarded as symptomatic of illness. The dilemma is to achieve the kind of interpersonal union and 'mature love' in which "two beings become one and yet remain two" (E. Fromm, 1964).⁽²⁾

Although the danger of engaging in substitute and distorted forms of union is inherent in the process of participation, health must include the totality of the interpersonal and social structures to which the person belongs. Wholeness cannot be purely individual or individualistic; it must include the personal and communal relationships in which the person participates and which may have a profound influence on the individual's experience of health and illness.

This fundamental fact is stressed by R.A. Lambourne (1963),⁽³⁾ who draws on medical, psychiatric and biblical insights to devote particular

(1) As mentioned elsewhere (q.v. Chapter 2), this is without doubt the most serious criticism directed at traditional Christian beliefs and practices and has been expressed by many writers, including Christians:

(2) E. Fromm (1964), op.cit., p. 21.

(3) R.A. Lambourne, Community, Church and Healing, op.cit. Dr. Lambourne provides a detailed analysis of biblical teaching with respect to health and healing which, from this perspective, are firmly rooted in the context of community. It is in the context of community that man becomes "whole": "A man becomes what he potentially is, one with Christ, and thereby one with man and God." (Ibid., p. 108.)

attention to the communal and corporate aspects of health and healing. While it is true that disease may have social origins,⁽¹⁾ health and healing of the whole man can only occur in the context of community.⁽²⁾ Indeed, it is part of the ambiguity of life that disease, and even dying, may be meaningful and creative in the context of a caring and healing community.⁽³⁾ As Lambourne points out:

"The sickness of the patient is not merely a negative thing, of which no positive good can come, and of which the most that can be expected is its removal. It is the very means chosen by God to save the patient and the community around him."⁽⁴⁾

This is a fundamental biblical perspective. In the total pattern of communal relationships, the suffering, disease, or dying of an individual may be 'consecrated', invested with meaning, and may become a source of healing for the community at large.⁽⁵⁾ In the fellowship of the Body of Christ, a caring community, suffering may be the way to healing; for example, as Lambourne observes, "a man who has a congenital defect, about which he is chronically embittered, may be saved by the loving service and prayers of another person or group, and yet retain his congenital deformity, whilst one of the group who has been involved may be relieved of a peptic ulcer".⁽⁶⁾ Situations of this kind reflect the ambiguity of life and also point to the dynamic potential for healing which exists in a caring community.

(1) R.A. Lambourne, *op.cit.*, pp. 1-22.

(2) *Ibid.*, Chapter 8: Corporate Aspects of Human 'Wholeness' in Recent Biblical and Medical Thought, pp. 90-111.

(3) *Ibid.*, pp. 109-111.

(5) *Ibid.*, p. 109-110.
op.cit., pp. 86-87.
 concentration of the group could be invested with meaning and could serve as a source of healing.

Despite the hazards involved, health is characterized by responsible participation in the physical and social world, by a capacity to engage in satisfying and intimate interpersonal relationships, by an ability to establish secure social foundations and to adapt to an ever-changing environment. Conversely, the lack of a secure social structure, an inability to engage in intimacy, and an inflexibility which is incapable of adaptation and self-alteration, are properly regarded as manifestations of illness.

(iii) Self-Transcendence and Spiritual Self-Affirmation

The third process which is constitutive for life is self-transcendence, which corresponds with Tillich's concept of spiritual self-affirmation.⁽¹⁾ Man is a spiritual being with a capacity for self-transcendence, a capacity for intentionality, self-detachment, and commitment to ultimate goals and values, which is essential for health. In order to exist (ex-istere: to stand out, to stand beyond) and to actualize his potential, man needs spiritual foundations which provide his life with a framework of meaning and which unify all other dimensions of his existence. Health then is "a spiritual quality available to us now, an integrated unity of the many-sidedness of human personality" (W.M. Miller, 1964).⁽²⁾

Self-transcendence is the source of vitality:

"Man's vitality is as great as his intentionality; they are interdependent. This makes man the most vital of beings. He can transcend any given situation in any direction and this possibility drives him to create beyond oneself without losing oneself" (P. Tillich, 1952).⁽³⁾

(1) P. Tillich (1963), op.cit., p. 92 ff.; and (1952), op.cit., p. 53 ff.

(2) W.M. Miller (1964), op.cit., p. 11.

(3) P. Tillich (1952), op.cit., p. 84.

Self-transcendence, in this view, has the character of intentionality which in turn is the source of vitality and distinguishes man as a mindful, intentional, and free agent. This vitality and intentionality is expressed in the courage to be, the courage of self-affirmation in spite of the perpetual threat of non-being,⁽¹⁾ and is manifest in faith, that is in "the state of being ultimately concerned" (P. Tillich, 1957 (b)).⁽²⁾

Faith or ultimate concern, as the expression of man's capacity for self-transcendence, fulfils the vital function of providing man's life with a framework of meaning and an integrating focal point:

"If faith is the state of being ultimately concerned all preliminary concerns are subject to it. The ultimate concern gives depth, direction and unity to all other concerns and, with them, to the whole personality" (P. Tillich, 1957(b)).⁽³⁾

Without the unifying power of faith and without the over-riding sense of meaning and direction it affords, man would lose vitality and become subject to physical and mental decay. Faith, expressed in the courage to be, transcends, unites, and gives meaning to both individualization and participant and is apparent in the act of affirming oneself both as an individual in spite of the risk of "losing one's world in empty self-relatedness" and as a participant "in spite of the risk of losing oneself and becoming a thing within the whole of things" (P. Tillich, 1952).⁽⁴⁾ Without a basis of faith and lacking intentionality, self-affirmation would be inconceivable and man could only give way to

(1) P. Tillich (1952), op.cit., p. 152.

(2) P. Tillich (1957 (b)), op.cit., p. 11. Also see P. Tillich (1957 (a)), op.cit., p. 1 ff., and P. Tillich (1965), Ultimate Concern (S.C.M. 1965), pp. 4-28.

(3) P. Tillich (1957 (b)), op.cit., p. 11.

(4) P. Tillich (1952), op.cit., p. 152.

despair or else settle for a superficial existence based on compromise and expediency.

Faith, as the state of being ultimately concerned and expressed in the courage to be, cannot be localized in a particular dimension of man's being. The experience of faith is "embedded in the totality of psychological processes" (P. Tillich, 1957 (a))⁽¹⁾ and "is the centred movement of the whole personality toward something of ultimate meaning and significance (P. Tillich, 1957 (b))."⁽²⁾ It involves every aspect of the personality, body, mind, emotions, and will. Attempts, for the purpose of scientific inquiry, to reduce faith to the proportions of a defensive function of the ego, or a product of conditioned learning processes, or an irrational emotional disturbance, deny man's capacity for self-transcendence and reduce man to the status of a mindless automaton, totally subject to the material contingencies of his existence. Faith involves and embraces every aspect of the person as an integral whole.

Like other aspects of his experience, faith is not without its ambiguities. While faith is an expression of man's spiritual freedom and intentionality, paradoxically it cannot be derived or produced by a self-conscious quest or search. Faith and courage involve the polarity between freedom and destiny inherent in human existence. On one hand, faith and courage are given, they are ontological. Man is "grasped by"⁽³⁾ ultimate concern as he is confronted with his destiny, with the particular meaning and responsibilities of his life. "Man is driven toward faith",

(1) P. Tillich (1957 (a)), op.cit., p. 8.

(2) P. Tillich (1957 (b)), op.cit., p. 11.

(3) P. Tillich (1965), op.cit., pp. 7-18.

according to Tillich, "by his awareness of the infinite to which he belongs, but which he does not own like a possession" (P. Tillich, 1957 (a)).⁽¹⁾ So man is "driven toward" faith by his awareness of the infinite possibilities open to him and is a measure of man's "level of aspiration" (Cf. W. Oates)⁽²⁾ and of man's "awareness of the realm of unattained possibilities" (Cf. A. Boisen).⁽³⁾ In each of these views, faith is bound up with man's destiny and expresses man's awareness of his infinite potentialities.

The idea that man is "grasped by" faith seems to be a denial of human freedom. The paradox is that, on the other hand, faith provides the basis of man's freedom. It is only by faith that man is able to actualize his potential being and to fulfil his destiny. In the words of G.W. Allport, faith establishes a framework of meaning and "provides the forward intention that enables him (man) at each stage of becoming to relate himself meaningfully to the totality of Being".⁽⁴⁾ This is the basis of man's freedom and intentionality. The courage of faith prevents man from taking refuge in absolute and sterile security and sets him free to actualize his potentialities and to decide "what he will become in the next moment" (V. Frankl, 1959).⁽⁵⁾

So faith and courage arise out of man's destiny and, paradoxically, are expressions of man's freedom. Through self-transcendence man discovers his destiny and is confronted with his potentiality and responsibility; but it is only through self-transcendence and commitment

(1) P. Tillich (1957 (a)), op.cit., p. 9.

(2) W.E. Oates (1955), op.cit., p. 30.

(3) A.T. Boisen, "The Psychiatric Approach to the Study of Religion" (1928) in O. Strunk (ed.), op.cit., p. 232.

(4) G.W. Allport (1955), op.cit., p. 96.

(5) V. Frankl (1959), op.cit., p. 132.

to ultimate values and goals, that is through ultimate concern, that man becomes free to affirm his being courageously.

The concept of self-transcendence and the conviction that faith, or a framework of meaning, is constitutive for health are not esoteric notions confined to theologians and philosophers. As a physician has observed, the psychiatrist has "theoretical and empirical reasons" for believing that the person who has found something in this world "for which he wishes to live and die", something of ultimate concern, something which gives meaning to all other meanings, is healthier than he who has not.⁽¹⁾ There are now many within the disciplines of medicine, psychiatry and psychology who subscribe to the view that faith, incorporating a sense of meaning and over-riding commitment to ultimate values and goals, is constitutive for health.⁽²⁾

The case is stated most emphatically and most convincingly by Viktor Frankl,⁽³⁾ the eminent Austrian psychotherapist. From his experiences in a concentration camp he became convinced of the vital necessity of a sense of meaning for man's health and well-being. He observed that in such extreme circumstances

"The prisoner who had lost his faith in the future - his future - was doomed. With his loss of belief in the future, he also lost his spiritual hold; he let himself decline and became

(1) G. Booth in P.B. Maves (ed.), op.cit., p. 14.

(2) For example see C.G. Jung (1934), op.cit.; V. Frankl (1959), op.cit.; G.W. Allport (1955), op.cit.; R. Daban (1955), op.cit.; W.M. Millar (1964), op.cit.; A.A. Schmale (1955), op.cit.; W.E. Oates (1955), op.cit.; and others.

(3) V.E. Frankl, Man's Search for Meaning (1959), op.cit.

subject to mental and physical decay".⁽¹⁾

In the absence of a sense of meaning, orientated toward the future, boredom and emptiness break into a man's life and he becomes lost in an "existential vacuum".⁽²⁾ In the event of being unable to invest his life with meaning, man may seek to fill the vacuum by demonstrating "a will to power" or "a will to possessions" or "a will to pleasure", none of which is ultimately satisfying.⁽³⁾ If meaninglessness and emptiness are overwhelming then a man may simply surrender his existence to disintegration or actively terminate it in despair.

On the basis of his observations Frankl established a therapeutic procedure, Logotherapy,⁽⁴⁾ orientated toward the meaning of the patient's life. By "meaning" Frankl is not referring to an abstract or general meaning of life. It is necessary, rather, for the particular person to discover the specific and concrete meaning of his life as a distinctive and unique individual.⁽⁵⁾ This particular meaning cannot be invented, it must be discovered, it is given in the particular responsibilities and tasks which life sets for him. While this search may create tension rather than equilibrium, man's search for meaning is an "indisputable prerequisite of mental health"⁽⁶⁾ - we would say, an indisputable prerequisite of total health.

(1) V. Frankl (1959), op.cit., p. 74. This conviction, based on Frankl's personal observations, is expressed in general terms by R. Dubos (1960), op.cit., p. 220: "The satisfactions which men crave most, and the sufferings which scar their lives most deeply, have determinants which do not reside in the flesh or in the reasonable faculties and are not completely accounted for by scientific laws. ...Because man is a spiritual body he is more concerned with a way of life than with his physical state". Compare with C.G. Jung (1934), op.cit., pp. 256-269 and with G.W. Allport (1955), op.cit., p. 75 ff.

(2) Ibid., p. 107-8. Compare with C.G. Jung (1934), op.cit., p. 269.

(3) Ibid., p. 108. (4) Ibid., pp. 97-137.

(5) Ibid., pp. 77, 98-99, 110-112.

(6) Ibid., p. 105.

But this does not mean that any faith, that is any 'framework of meaning' or any 'state of ultimate concern', is intrinsically healthy without discrimination. Faith can take "profane" and "demonic" forms⁽¹⁾ with destructive effects in a person's life for, as Tillich observes, "The history of faith is a permanent fight with the corruption of faith" (P. Tillich, 1957 (a)).⁽²⁾ There can be no doubt that faith "can be a constructive, creative, healing, life-affirming force or a dark, repressive, life-crippling force, depending on the way it is understood and used" (H.J. Clinebell, 1965).⁽³⁾

Faith may take the form of fanatical adherence to a rigid system of dogma in the hope of achieving freedom from insecurity and doubt. But such absolute security does not exist in the context of human existence. Faith in its very nature is always partial and provisional, and this element of uncertainty in faith cannot be removed.⁽⁴⁾ If the content or object of fanatical faith is destroyed or breaks down, then the effects in a person's life may be disintegrative as emptiness breaks in.⁽⁵⁾ Faith cannot afford the hoped for security or serenity, not in an absolute sense.

A person may use his faith as a means of escape from reality. He may become so absorbed in otherworldliness that he becomes detached from real concerns in the world. Such a process is inherently life-denying

(1) P. Tillich (1963), *op.cit.*, p. 104 ff.; (1965), *op.cit.*, pp. 19-28.

(2) P. Tillich (1957 (a)), *op.cit.*, p. 79.

(3) H.J. Clinebell (1965), *op.cit.*, p. 28. Compare with L.D. Weatherhead (1951), *op.cit.*, p. 419 ff.; W.E. Oates (1955), *op.cit.*; W.M. Millar (1964), *op.cit.*; A.A. Schneiders (1964), *op.cit.*; and D.E. Roberts in P.B. Maves (ed.), *op.cit.*, pp. 26-28.

(4) P. Tillich (1957 (a)), *op.cit.*, pp. 16-20.

(5) *Ibid.*, pp. 17, 109.

and its effects disintegrative rather than integrative.

A common and particularly destructive form of faith is that which emphasizes self-surrender and self-abrogation and which fosters submission, compliance, passivity and conformity. This is the most serious criticism which is directed at Judaeo-Christian religion: that it contains endless exhortations commanding men to be helpless, self-abnegating, and compliant.⁽¹⁾ If this is so then it must be recognized as being unhealthy. As Tillich expresses it, "The submissive self is the opposite of the self-affirming self, even if it is submissive to a God",⁽²⁾ and, moreover, a God who appears as "an invincible tyrant" who deprives all other beings of freedom and subjectivity needs to be put to death.⁽³⁾ A faith which requires self-negation, the rejection of basic needs, and the suppression of fundamental human emotions is inherently demonic and destructive.

It is equally possible, however, that a person may use his faith as a means of self-assertiveness. A person may express his faith in an attempt to achieve absolute perfection, holiness, and self-righteousness, which is essentially an individualistic and narcissistic goal. This may well betray underlying feelings of profound guilt and insecurity. But the inevitable failure to attain such perfectionist standards may be self-destructive, expressed in overwhelming guilt and the loss of self-respect, and lead to the destruction of others, expressed in judgmentalism and intolerance toward others.

(1) In particular see T.S. Szasz (1961), *op.cit.*, pp. 192-203. Also compare with A. Storr (1960), *op.cit.*, p. 43-4.

(2) P. Tillich (1952), *op.cit.*, p. 39.

(3) *Ibid.*, p. 179.

There are many ways in which faith may be distorted and corrupted with destructive and disintegrative effects in personal life. Whether faith is integrative or disintegrative depends upon the way in which it is communicated, introjected, understood and expressed in the particular person's life. Particular beliefs and practices may be integrative or disintegrative in their effects. What is then needed are criteria by which healthy and unhealthy forms of faith can be distinguished. Two basic criteria may be applied.⁽¹⁾

It is possible, in the first place, to make a utilitarian evaluation of the "fruits" of the particular beliefs and practices involved in a form of faith according to whether they are integrative or disintegrative in effect.⁽²⁾ For instance, as A.A. Schneiders comments, "if religion, whether as a system of dogma or as a group of practices, can gratify basic needs, help reduce conflict or frustration, modify anxiety, and bring peace of mind to the troubled penitent, then it is serving the aims of mental hygiene".⁽³⁾ It could then be said that such a faith was

- (1) H.J. Clinebell (1965), *op.cit.*, pp. 31-52, in the form of questions, formulates twelve criteria by which healthy and unhealthy religion may be differentiated. (i) How does a religion effect interpersonal relationships? Does it serve to build bridges or barriers between people? (ii) Does it strengthen basic trust and relatedness in the Universe? (iii) Does it hamper or stimulate the growth of inner freedom and personal responsibility? (iv) Does it foster a repressive or positive attitude to one's body, emotions and person? Does it lessen or increase the enjoyment of life? (v) Does it provide an effective or faulty means of moving from guilt to forgiveness? (vi) Does it handle the vital energies of sex and aggression in constructive or repressive ways? (vii) Does it encourage the acceptance or denial of reality? (viii) Does it emphasize love or fear, violence or growth? (ix) Does it provide a frame of orientation and an object of devotion which is adequate in handling existential anxiety constructively? (x) Does it encourage the individual to relate to his unconscious through living symbols? (xi) Does it accommodate itself to the neurotic patterns of the society or does it seek to transform them? (xii) Does it serve to strengthen or weaken self-esteem?

These questions provide helpful guidelines for the evaluation of healthy and unhealthy forms of religious beliefs and practices.

- (2) This is the test applied by W. James (1903), *op.cit.* p. 15.

- (3) A.A. Schneiders (1964), *op.cit.*, p. 15.

salutory in its effects. The fundamental question is whether a particular form of faith fosters self-affirmation or self-negation.

In making a pragmatic evaluation of this kind, three fundamental questions could be posed. Does faith foster or deny biological affirmation and physiological integration? The healthiness of a faith is contingent upon whether or not it encourages a positive attitude to one's body and the satisfaction of basic physical needs and upon whether it lessens or increases the enjoyment of life. In the second place, does faith enhance or reduce a person's psychic self-integration? The healthiness of a faith is contingent upon whether or not it fosters the growth of individuality, self-identity, self-respect, and inner freedom, or whether or not it enables a person to fulfil his unique potential, or whether it encourages or suppresses the positive expression of emotions. Then, thirdly, does faith encourage interpersonal union, a sense of community, and responsible participation in the physical and social world? The healthiness of a faith is contingent upon whether or not it enhances the growth of interpersonal relationships within the context of community and whether or not it encourages responsible participation. If a faith, or the particular beliefs and practices associated with it, cannot meet these requirements it cannot be said to be healthy and integrative.

The position is summed up by W.E. Oates:

"In essence, then, healthy religion binds people together in such a way that their individuality is enabled both to be realized and to be consecrated to the total community of relationships to which they belong. This is in a religion of mature and responsible relatedness".⁽¹⁾

In short, the basic question is whether a faith stunts or enhances the multilateral growth and affirmation of the whole person both as an individual and as a participant.

(1) W.E. Oates (1955), op.cit., p. 113.

In evaluating the healthiness or unhealthiness of faith, however, it is necessary to go beyond purely pragmatic and utilitarian considerations. If these were the only criteria then the content of faith would be inconsequential so long as it was seen to produce salutary effects in personal life. The question must also be faced as to whether or not a particular faith is in fact an expression of "ultimate concern" and whether or not it does provide a unifying framework of meaning for personal life.

Tillich advocates the view that "ultimacy" is the criterion for distinguishing between authentic faith and idolatrous faith, and ultimacy means nothing finite: "Nothing which by its very nature is finite can rightly become a matter of ultimate concern".⁽¹⁾ Oneself, a mother, a family, a political philosophy, mankind, or a nation, any one of these may be matters of provisional concern, even matters of very considerable concern, but they cannot be regarded with ultimate concern because they are finite. If any one of these concerns is made a matter of ultimate concern, that is deified and invested with ultimacy, then it is idolatrous and the consequences ~~of~~ are always destructive.⁽²⁾ Each of these concerns, important though they may be, are provisional and are bound by the condition of finitude. They may provide preliminary integrating power but they are bound to break down sooner or later and the consequent emptiness and loss of meaning can only be destructive and disintegrative.⁽³⁾

(1) P. Tillich (1965), *op.cit.*, p. 24.

(2) *Ibid.*, p. 24-5.

(3) P. Tillich (1958 (a)), *op.cit.*, p. 109. Compare with C.G. Jung (1934), *op.cit.*, p. 269; V. Frankl (1959), *op.cit.*, p. 108; P. Tournier (1968), *op.cit.*, p. 54-56.

Authentic faith must have the quality of ultimacy, of ultimate concern, and as such it expresses man's apprehension and awareness of the ultimate and the infinite. Such ultimate concern is essentially religious and can only come out of an encounter with and experience of God's love and acceptance:

"The courage to be in this respect is the courage to accept the forgiveness of sins; not as an abstract assertion but as the fundamental experience in the encounter with God".

(P. Tillich, 1952).⁽¹⁾

This faith or state of ultimate concern cannot be derived or produced self-consciously: it is given through the experience of God's acceptance which is expressed and embodied in finite realities.⁽²⁾ The revelation par excellence of God's love is its embodiment or incarnation in Jesus as the Christ, as the courageous man, as the symbol of New Being. Ultimate concern, based on the acceptance of God's unconditional love manifest in Jesus as the Christ, is not another concern alongside or over-against all other concerns; it over-rides and underlies and unifies all provisional concerns.⁽³⁾ This faith is the source of the courage to be and sets man free to courageously affirm his being as an integrated and unique individual, as an interrelated and responsible participant, and as a self-transcendent and spiritual being. This faith, expressed in love and courage, provides the power of reconciliation, reconciliation with oneself, with others and with one's world, and with God, which breaks through estrangement. Only such faith and courage

(1) P. Tillich (1952), *op.cit.*, p. 161.

(2) P. Tillich (1965), *op.cit.*, p. 28.

(3) *Ibid.*, p. 27: "...the unconditional or ultimate should not be viewed as part of a pyramid, even if its place is at the top. For the ultimate is that which is the ground and the top at the same time, or the embracing of the pyramid."

can overcome despair and meaninglessness, and it is only out of such faith that self-affirmation and the reintegration of the whole personality is possible. Ultimate concern, as man's awareness of God's acceptance, is expressed essentially in the integrating and reconciling power of love, the power of self-love, love of others, and love of God. This spiritual foundation is essential to man's health and the affirmation of his being.

THE COURAGE TO BE

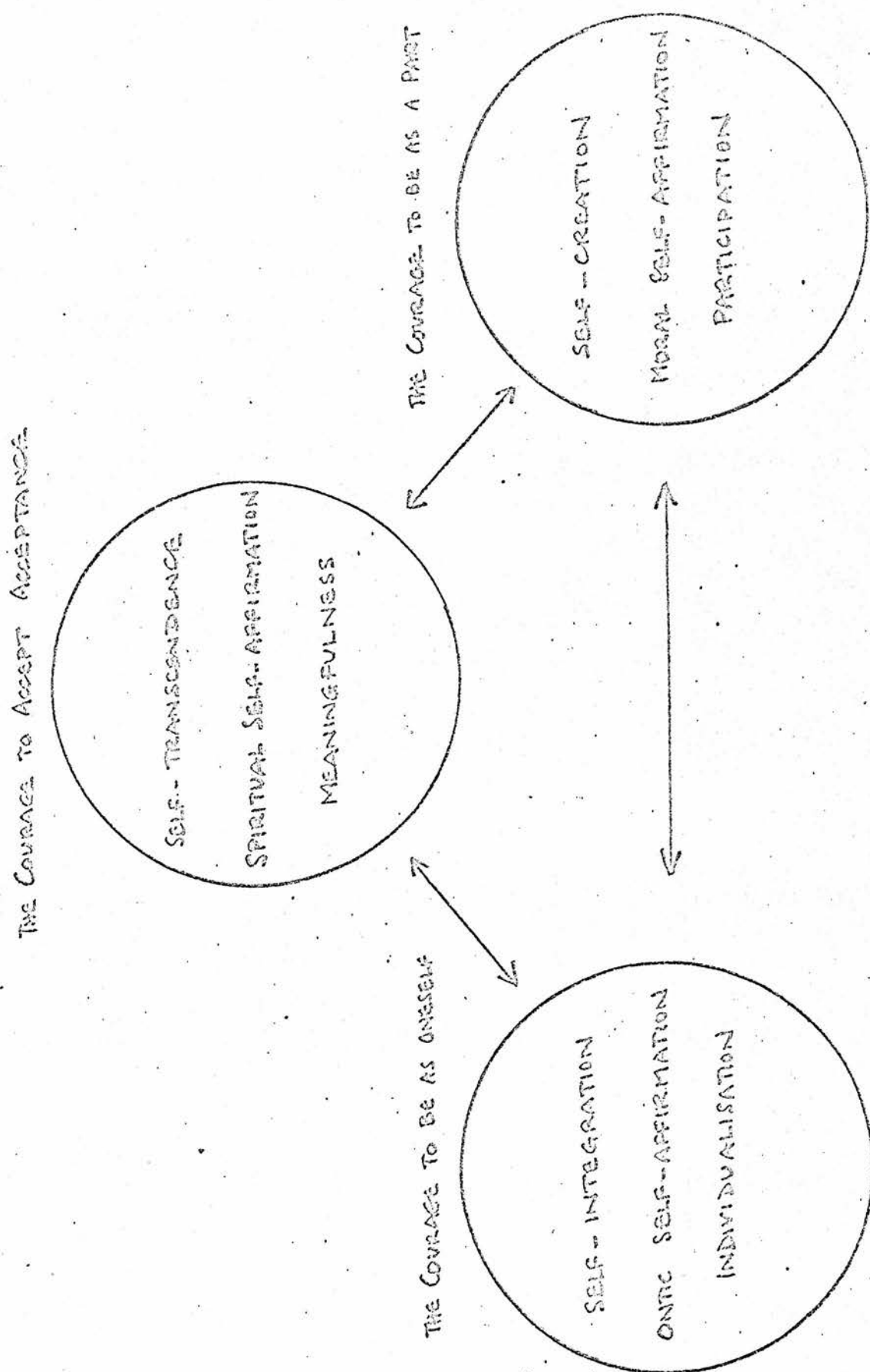
Like other concepts of health, the perspective presented here implies an ideal or ultimate concept of wholeness. The ideal form of wholeness is conveyed in Tillich's concept of "the courage to be". By faith, man is given the courage to affirm his being in spite of the fact of non-being which hangs over his existence. Through his courage man is enabled to affirm his potentialities in spite of the conditions, categories and polarities which structure his existence and in spite of the anxiety provoked by his awareness of the threat of ceasing to be. Through this courage man is given the power to find affirmative and satisfying solutions to the possibility of unlimited despair. This courage, which is given to man, provides the power of self-affirmation and is an expression of man's vitality.

The courage to be has three dimensions which are distinguishable but not separable, they are dynamically interrelated, and they correspond with the basic functions or processes of life. An attempted conceptualization of the courage to be is offered in Figure 2 (over).

(i) Courage and Individualization. The courage to be as oneself⁽¹⁾ is an expression of self-affirmation and is constitutive for health. The courage to be as oneself is the courage to discover and fulfil one's

(1) P. Tillich (1952), op.cit., pp. 114-151.

FIGURE 2 : LIFE PROCESSES & THE COURAGE TO BE .



uniqueness, it is the courage to affirm one's freedom and individuality as an integrated person, it is the courage to stand as a separate, differentiated, and incomparable individual. This courage is expressed in individualization, self-integration, self-identity, and self-respect, and is the courage to be a unique individual in spite of the potential loss of self in isolation and separation.

(ii) Courage and Participation. The self-affirmation of the individual self without regard for its relatedness with other selves and without regard for its responsibility as a participant in its world is the essence of destructive individualism and selfishness. The courage to be as a part⁽¹⁾ is therefore a necessary component of self-affirmation and is constitutive for health. The courage to be as a part is the courage to enter into the process of mutual affirmation in the context of social and communal relationships, it is the courage to engage in satisfying and intimate interpersonal relationships, it is the courage to affirm one's responsibility and accountability as a participant in the world. This courage is expressed in relatedness, mature dependence, respect and love toward others, and in responsibility, and is the courage to affirm oneself as a participant in spite of the potential loss of self in self-negation and condemnation.

(iii) Courage and Transcendence. Beyond the polarity of individualization and participation, self-affirmation is characterized by the courage to transcend oneself and the contingencies of one's immediate existence.⁽²⁾ The courage of self-transcendence is the affirmation of one's spiritual being, and it is only thus, by openness to the divine-human encounter, that one is grasped by the fact that one is "accepted in spite of being unacceptable".⁽³⁾ When one is grasped by the fact of God's acceptance

(1) P. Tillich (1952), op.cit., pp. 89-113.

(2) Ibid., pp. 152-183.

(3) Ibid., p. 160.

and forgiveness, and when one has the courage to accept this acceptance, then one is given the basis of self-acceptance and the basis of the acceptance of others. Self-transcendence and the courage to accept acceptance is expressed in ultimate concern, intentionality, commitment to ultimate values and goals, and in a sense of meaning which transcends and unifies individualization and participation. This is the courage to affirm one's being as a spiritual being, as a mindful, intentional and purposive agent in spite of the potential loss of self in meaninglessness and emptiness.

It is an inescapable fact, however, that the courage to be in each of its aspects is never absolute and man's potential self-affirmation as an individual, as a participant, and as a self-transcendent being is never fully realized within the conditions of existence. Processes of health and illness, of integration and disintegration, are ambiguously mixed together in each dimension of man's being. The courage to be therefore implies risk and is an expression of faith. As it is expressed in man's life, it is always courage "in spite of", courage in spite of the risks of disintegration, destruction, and despair implicit in the structures of existence, and it is the courage to positively come to grips with the anxiety of separation, guilt, and meaninglessness. Such courage is only possible by faith and is an affirmation of faith.

SUMMARY

It has been necessary to consider the concept of health at some length because of the misunderstandings and disagreements surrounding the use of the term. It was also necessary to establish criteria by which Church of Scotland ministers' experiences of health and illness could be identified and evaluated. The concept of Total Health, that is a concept which embraces and unifies the physiological, intrapersonal,

interpersonal, and spiritual dimensions of man's being, is intrinsic to the conceptual framework of this study. This concept of total health is derived from an existential-ontological perspective of the nature of man and his existence, and is holistic, personal, dynamic and multidimensional in character.

The concept of Total Health begins with the priority and uniqueness of the person as an integral whole. From this perspective, health and illness are expressions of the person's being-in-the-world. Health is manifest in any processes of integration which serve to affirm the person's unity and unique potential; illness appears in any processes of disintegration which disrupt or destroy the person's fundamental unity.

However, from this perspective, it is also seen that the fundamental unity and integrity of the person is constantly threatened by division, disease, distortion, and disease, and by the absolute fact of death. Man is bound by the conditions, categories, and polarities of existence in which he participates. Under these conditions, health is fragmentary in all its forms and health and illness are ambiguously mixed together in the person's total experience. In face of actual or potential threats to his being, confronted with the fact of non-being which is implicit in his being, man experiences anxiety as the awareness of his finitude. This existential anxiety, which is an inescapable and universal experience of man, plays a vital part in the person's experience of health and illness either as a constructive or destructive force which drives him in the direction of either self-affirmation or self-negation.

Within the conditions of existence, man's being is multidimensional and his growth is multilateral. Therefore, while health and illness are expressions of the whole person, a multilateral approach to the study

of health is necessary. Four fundamental processes are constitutive for man's life and are characteristic of health, and these processes provide the criteria by which health and illness may be identified and evaluated.

(i) Biological affirmation is constitutive for life, and health is characterized by integrated and harmonious physiological functioning. Biological integration and the satisfaction of basic physical needs provide the basis of a free and secure life. Therefore, we will be concerned with processes of integration and disintegration in the organic dimension of ministers' experience. But health consists of more than biological survival purely for the sake of survival.

(ii) Self-integration and self-identity is constitutive for life, and health is characterized by individualization, differentiation, inner freedom, and self-respect. The courage to be as oneself, as a unique, separate, individuated self, provides the person with a coherent and integrated centre which is necessary for his existence. We will therefore be concerned with manifestations of self-identity, self-respect, and self-love in the experience of ministers. At the same time, paradoxically, it will be assumed that self-integration may be too intensive and may be disintegrative when it is expressed in individualistic self-assertiveness, excessive preoccupation with one's self, self-absorption and selfishness.

(iii) At the opposite pole, self-creativity and self-alteration are constitutive for life, and health is characterized by a capacity to engage in satisfying and intimate interpersonal relationships, an ability to establish and participate in a secure structure of social relationships, and by responsible participation in the physical environment. The courage to be as a part, as a related, interdependent, and responsible participant, is necessary to the person's self-affirmation.

It is only through participation and in the context of relationships that he is able to affirm his integrity and identity. A dialectical relationship exists between the processes of self-identity and self-alteration. As the third criteria, we will be concerned particularly with the interpersonal dimension of ministers' experience, with their capacity to engage in intimacy and their ability to establish secure social foundations. It will also be assumed, again paradoxically, that self-alteration may become too expansive and may be destructive when it is expressed in passive submissiveness, conformity, compliance, and self-abrogation.

(iv) Finally, self-transcendence and spiritual self-affirmation is regarded as being constitutive for life. Indeed, self-transcendence has the character of intentionality and is the expression of man's vitality. Vitality and intentionality are dynamically interrelated. Health is characterized by an over-riding sense of purpose and meaning, by commitment to ultimate goals and values which transcends and unifies other dimensions of man's being, and by a vital courage to be in spite of the hazards and threats inherent in the structure of existence. We will be concerned, fourthly, with the spiritual dimension of ministers' experience, with their sense of meaning, with their ultimate concern and with their ability to relate their existence to values beyond themselves, and particularly with the constructive and destructive effects of a religious vocation in their total experience.

Despite the ambiguities and paradoxes involved, our approach to health and illness in the experience of these ministers will be multi-lateral and our attention will be focussed on the physical, intrapersonal, interpersonal, and spiritual dimensions of their experience as unique and integrated persons.

CHAPTER 4

METHODOLOGY: EXISTENTIAL ANALYSIS

"We have been deluded by the fact that the methods employed for the study of man have been for the most part those originally devised for the study of machines or the study of rats, and are capable, therefore, of detecting or measuring only those characteristics which the three have in common."

J.W. Krutch (1954).⁽¹⁾

In undertaking an inquiry into any aspect of human life the investigator is faced with the problem of adopting a method which does justice to man qua Man without reducing persons to the status of machines or organisms or animals, and which, at the same time, is faithful to empirical facts without distortion. Allied to this is the fact that the investigator as a person is inevitably involved as a participant in his own inquiry. This tension, between essential and empirical truth and between objectivity and subjectivity, is nowhere more acute than in the realm of health and illness. In constructing a methodology appropriate to the study of health and illness in the experience of Church of Scotland parish ministers it was necessary to satisfy four prior requirements.

The first requirement was to adopt a method which would be holistic and personal in orientation; that is, a method which would respect the priority and unity of the person as an integral whole.

Secondly, a method was required which would facilitate "multi-level analysis"⁽²⁾ of health and illness as they appear in the various dimensions of a person's being. The person is not a simple monad with a monolithic

(1) J.W. Krutch, The Measure of Man (Bobbs-Merrill, 1954), p. 32.

(2) I.G. Barbour, *op.cit.*, p. 331 (Cf. C. Grobstein).

structure but is a "multi-levelled unity".⁽¹⁾ Therefore, a method was required which would open the way to investigate processes of health and illness within the dimensions which comprise the integrated person.

In the third place, it was necessary to adopt a method which would make it possible to identify the inter-dimensional processes of integration and disintegration as they refer to the experience of the whole person. Such a method would have to be dynamic, flexible, and trans-disciplinary, while at the same time providing a reliable foundation of empirical data from which valid generalizations could be drawn.

Then, fourthly, the method would have to afford access and insight into the realm of experience as distinct from external behaviour or symptoms. Behaviour, studied from a detached and objective standpoint, may be symptomatic of the person's total experience. But, nevertheless, behaviour is only a function of experience⁽²⁾ and can only be interpreted in terms of the observer's own purposes, expectations, and life experiences. Such an interpretation may bear little relation to the actual experience which lies behind the other's behaviour. The method, therefore, would have an experiential rather than behaviouristic orientation.

In adopting a method for the purposes of this inquiry, it was considered that Existential Analysis applied as a method of research would meet these requirements. By applying the basic principles of Existential Analysis it has been possible to construct a methodological framework which is holistic, multilateral, dynamic, and experiential in nature.

(1) I.G. Barbour, *op.cit.*, p. 363. Also discussed *q.v.* Chapter 3.

(2) Cf. R.D. Laing (1967), *op.cit.*, pp. 15-38.

EXISTENTIAL ANALYSIS

It is nothing new to propose the adoption of existential analysis (daseinsanalyse) as a method of research or as "a method of discovery in therapy".⁽¹⁾ There is clear evidence of the growing contribution of existentialism in the fields of research and psychotherapy and, as was suggested earlier, it is the conviction of those engaged in such inquiries and therapeutic endeavours that existential analysis widens the scope of any appraisal of reality and opens up new possibilities for the study of man.⁽²⁾ At the same time, this development is not without its opponents and critics, some of whom regard it as an unwarranted intrusion into the realms of science and therapy by philosophy.⁽³⁾

The principles and procedures employed in existential analysis are discussed and illustrated elsewhere in greater depth than can be attempted in this context.⁽⁴⁾ For the purposes of this study, for which existential

(1) F.A. Macnab (1965), op.cit., p. 134-5.

(2) See discussion q.v. Chapter 3, pp. 143-146.

(3) This opposition is discussed by F.A. Macnab (1965), op.cit., p. 129 ff. For an example of a psychoanalytic critique of existential analysis as a therapeutic procedure see M.J. Feldman, "Queries on existential psychotherapy", International Journal of Social Psychology, Vol. IX, 2, 1963. For a sympathetic consideration of the pros and cons see P. Roubiczek, Existentialism: For and Against (Cambridge Uni. Press, 1964).

(4) For discussions of the general assumptions and characteristics of existential thought refer to the symposium edited by R. May (1958), Existence (Basic Books, 1958); and also the discussions presented by P. Roubiczek (1964), op.cit., and C. Michalson, Christianity and the Existentialists (Scribner, 1956). The application of existential analysis to psychiatry and psychology is considered in R. May (1958), op.cit., especially in essays by R. May, H.F. Ellenberger, and by Ludwig Binswanger. Also see F.A. Macnab (1965), op.cit., pp. 129-140; R. May (1961), Existential Psychology (Random House, 1961); R. Allers, Existentialism and Psychiatry (C.C. Thomas, 1961); I.A. Caruso, Existentialist Psychology (D.L.T., 1964). A variant approach to existential analysis is presented by V. Frankl (1959), op.cit., pp. 97-137, in his concept of "Logotherapy".

analysis provides a basic frame of reference, it will suffice simply to reaffirm the fundamental assumptions, attitudes, and emphasis which are implicit in existential analysis and which distinguish it from traditional scientific methodology. These assumptions have been foreshadowed in the preceding discussion on the concept of health.⁽¹⁾

(i) Personal. The existentialist approach, when applied to therapy or research, takes the indisputable priority of the person and his experience as its starting-point. It affirms the priority and unity of the person as a whole and seeks insight into the person's mode of being. As a method of discovery, existential analysis

"attempts to lay bare the fundamental structures of human existence and seeks to determine in which way a particular person appropriates or distorts these structures. In all, the existentialist approach is concerned with a person's mode of being, his being-with-others, his being-in-the-world".

(F.A. Macnab, 1965).⁽²⁾

Existential analysis is focussed on the whole person, his experience of himself, his experience of others, and his experience of the world of which he is part and in which he takes part.

(ii) Historical. As a careful and thorough appreciation of personal existence, existential analysis "adheres to historical data" and emphasises detailed historicity.⁽³⁾ The material with which existential analysis works is drawn from the observable realm and is associated with the individual's history. From such data, existential analysis attempts to uncover the unique structural patterns and themes of the individual life history.⁽⁴⁾

(1) q.v. Chapter 3, pp. 143-148.

(2) F.A. Macnab (1965), op.cit., p. 134.

(3) Ludwig Binswanger in R. May (1958), op.cit., p. 268-9, in presenting "The Case of Ellen West", one of the outstanding examples of existential analysis as employed in a therapeutic situation.

(4) Ibid., p. 223, 268-9, 314 ff.

(iii) Behaviour and Experience. Existential analysis, however, is concerned with more than the externals of a person's history; that is, with more than information about a person. Such information may be valuable in constructing a total picture but it can only be interpreted in terms of the observer's frame of reference which may conceal or distort what is really happening inside the total experience of the subject.⁽¹⁾ From an existentialist point of view the subject's experience is primary and attempts by an observer, or a therapist, to impose his own interpretation or experience on the subject's experience is a denial of the subject's integrity. Existential analysis is therefore subject-centred and experiential.

Experience, as R.D. Laing asserts, is the only evidence in the study of man:

"I cannot experience your experience. You cannot experience my experience. We are both invisible men. All men are invisible to one another. Experience is man's invisibility to man. Experience used to be called the Soul. Experience as invisibility of man to man is at the same time more evident than anything. Only experience is evident. Experience is the only evidence. Psychology is the logos of experience."⁽²⁾

Existential analysis therefore directs attention to the inner and transcendent aspects of human existence as well as to the external and objective facts of behaviour. On this basis it can claim to be a logos of the human psyche as it attempts to explore the "inner-world" of personal experience.

But, as R.D. Laing himself asks, "how can one ever study the experience of the other? For the experience of the other is not evident

(1) See R. May (1958), op.cit.: R. May, pp. 7-9, and H.F. Ellenberger, pp. 37-39.

(2) R.D. Laing (1967), op.cit., p. 16.

to me, as it is not and never can be an experience of mine".⁽¹⁾

Although it is not readily acknowledged, this problem confronts anyone engaged in the human sciences.

(iv) Encounter and Inter-experience. It is patently evident that experience cannot be studied from the position of an onlooker or from outside by detached, objective observation, if, indeed, that can be achieved in any field of study. Experience is only disclosed in the context of a shared, mutual experience. That is to say, experience only emerges in the framework of an interpersonal experience involving encounter, participation, and dialogue. The disclosure of experience can only occur in the realm of "inter-experience":

"The study of the experience of others, is based on inferences I make, from my experience of you experiencing me, about how you are experiencing me experiencing you experiencing me.....

Social phenomenology is the science of my own and of the other's experience. It is concerned with the relation between my experience of you and your experience of me. That is, with inter-experience."

(R.D. Laing, 1967).⁽²⁾

The experience of the other can only be known and appreciated in terms of what the other communicates and discloses, verbally or non-verbally, in the framework of mutual experience:

"There is no way to know about human personality other than by means of what one person conveys to another, that is, in terms of relationship with him."

(Fromm-Reichmann, 1950).⁽³⁾

Existential analysis attempts to enter the realm of inter-experience and emphasizes encounter, participation, and dialogue, and asserts

(1) R.D. Laing, (1967), op.cit., p. 16.

(2) Ibid., p. 17.

(3) F. Fromm-Reichmann (1950), op.cit., p. xiv.

that detached observation can never gain access to the core of the evidence in the study of man.

(v) Participant Observation. As it requires a framework of inter-experience, existential analysis requires the observer's participation and involvement. The investigator is required to be a "participant-observer" (Cf. H.S. Sullivan).⁽¹⁾ The existentialist approach refutes the ideal or myth of scientific detachment as the only way to truth in the realm of social sciences and denies the traditional dogma that the less one is involved in a given situation the more clearly one can establish the truth.⁽²⁾ The experience of the other can only be known through participation and, in any event, the observer and the observed are inextricably involved in some kind of relationship in any human inquiry. The evidence always arises out of the interaction between the object and the subject, the data are always a selection based on the investigator's purposes and expectations, and assessment of the evidence inevitably requires personal judgment. The investigator's personal involvement is an irrefutable, empirical phenomenon.⁽³⁾ What is at issue is the nature of that involvement: as to whether the investigator is to be involved as a supposedly detached, objective observer or as a participant observer.

The existentialist approach to research or therapy frankly acknowledges the investigator's participation. It is equally important, however, that the onus rests on him as a 'participant-observer' for careful, sensitive, and detailed observation and for unbiased evaluation made primarily in terms of the other's experience rather than in terms

(1) H.S. Sullivan (1954 (a)), op.cit., pp. 19-25. Also F. Fromm-Reichmann (1950), op.cit., p. 12, 32-34.

(2) Cf. R. May (1958), op.cit., p. 6, 27.

(3) Refer to I.G. Barbour, op.cit., pp. 176-205, for a consideration of the balance between objectivity and personal involvement in every scientific inquiry.

of his own experiences and preconceptions. This is a delicate balance to achieve or maintain, but it is fundamental to existential analysis.

(vi) Objective Facts and Subjective Processes. The acknowledgment of personal involvement does not mean, however, that objectivity is sacrificed or that existential analysis is based on a purely subjective appraisal and evaluation. The existentialist approach to research and therapy arose out of a desire to be more rather than less empirical and out of a wish to be faithful to human existence in its totality and in all its variety and subtlety.⁽¹⁾ Existential analysis represents an attempt to embrace and transcend the objective and subjective aspects of personal experience:

"Existentialism, in short, is the endeavour to understand man by cutting below the cleavage between subject and object which has bedevilled Western thought and science since shortly after the Renaissance".

(R. May, 1958).⁽²⁾

The existentialist movement expresses a reaction against the Hegelian exaltation of objectivity and "the totalitarianism of reason"⁽³⁾, especially as it appears in the scientific insistence on the objectification and treatment of the other person as an object.⁽⁴⁾ This does not mean that existential analysis dispenses with objectivity or that it abandons rationality in favour of irrationalism. But it

(1) R. May (1958), op.cit., pp. 3-8.

(2) Ibid., p. 10.

(3) Ibid., and also see F.A. Macnab (1965), op.cit., p. 131-3.

(4) This criticism of objectivity, especially as it affects a therapeutic relationship, is articulated by R.D. Laing (1960), op.cit., pp. 20-25, 27-31; and (1967), op.cit., pp. 15-21, 87-90.

does reject the totalitarian claims made for rationalism and detached objectivity.

Existentialism is concerned with a careful and sympathetic appreciation of human life in all its aspects and is a continual attempt to find a reasonable balance between objective factors and subjective processes in personal experience. Existential analysis requires painstaking and unbiased observation of objective phenomena and seeks to establish a reliable framework of empirical data. But it also recognizes that such data does not necessarily afford access to inner, subjective, and transcendent aspects of human experience... Therefore, existential analysis is directed toward the study of the subjective processes, moods, and emotions and the transcendent dimensions of personal experience. This can only be achieved by attempting to 'see' the world through the other's 'eyes' in terms of the other's experience, which requires empathic participation, something akin to Collingwood's principle of "imaginative identification"⁽¹⁾, and respect for the other's integrity. Through this dual process, existential analysis attempts a meaningful correlation of objective factors and subjective processes in human life.

(vii) Existential Motifs. The purpose of collecting and describing varieties of experience is to arrive at generalizations, to reach some assessment and interpretation of the evidence. Interpretations in existential analysis are generally made on the basis of existentialist motifs, which are concerned with the structures of existence and "the meaning-structures of the person's life and illness".⁽²⁾ The basic concepts and motifs with respect to health and illness behind this study have been explored at length in the preceding discussion. From an existential perspective, these concepts are always provisional and

(1) Cf. I.G. Barbour, *op.cit.*, p. 188.

(2) F.A. Macnab (1965), *op.cit.*, p. 135.

cannot be applied or imposed as a dogmatic, inflexible system. They provide guidelines for evaluation but the way must remain open to further discovery.

As Binswanger observes, the person's life history is usually thematic⁽¹⁾ and existential analysis seeks to discover and describe the themes and patterns of meaning which lie behind the symptoms and external phenomena. But these themes cannot be imposed from without; they can only arise out of the other's experience and can only be discovered through participation and by remaining open to the other's self-disclosure.

These are the basic assumptions inherent in existential analysis as a method of discovery in research or therapy and they are implicit in the methodological structure employed for this inquiry.

THREE PHASE PROGRAMME

In order to investigate Church of Scotland ministers' experience of health and illness a three phase programme was designed and, in conception, the format was constructed on the model of a diagnostic interview. The framework was based on three interrelated questions.

What does it mean to be a minister of the Church of Scotland and what conditions and characteristics distinguish them as a group? What kind of life-style do they share in common?

What are the empirical effects of being a minister on the individual's health? More explicitly, what is their experience of mortality and morbidity?

What is the nature of the personal experiences involved in the minister's life which are eventually expressed in mortality and morbidity?

(1) R. May (1958), op.cit., p. 223 f.

What are the effects of being a minister on the individual's experience of health and illness?

These questions correspond with the underlying questions by which a diagnostic interview⁽¹⁾ is carried forward and by which the interviewer seeks to gain progressively greater insight into the experience of the other person.

(1) The Minister's World and Life-Style

A diagnostic inquiry must begin by asking: "Who is this person?" At the initial encounter, it is necessary to discover the distinctive characteristics which identify the person as a unique individual and to establish the salient features of the person's present life-situation and place in the world. All subsequent disclosures and experiences then fit into and complement this framework.

The first phase of this project was undertaken in order to discover and describe those conditions, regulations, expectations, and functions which distinguish Church of Scotland parish ministers as a group. It is an attempt to clarify and appreciate the kind of life, or 'life-style', which these ministers share in common and to establish the conditions and structures of the minister's 'world'. Attention is focussed on the peculiar conditions which distinguish this group of ministers from those of other denominational traditions and from other occupational and professional groups.

This examination of the minister's 'world' and of the field-processes in which they are involved is not based upon abstract and theoretical

- (1) In a therapeutic framework, a diagnostic interview is considerably more complex than is suggested here. But there are three fundamental questions which have been paralleled in the structure of this study. For helpful discussions of diagnostic procedures in psychotherapy and counselling see F. Fromm-Reichmann (1950), *op.cit.*, pp. 45-68; C.R. Rogers, Counseling and Psychotherapy (Houghton Mifflin Co., 1942), pp. 51-84; E.S. Bordin, Psychological Counseling (Appleton-Century-Crofts, 1955), pp. 132-5.

considerations. The empirical foundation for this part of the inquiry was provided by a detailed study of four parish ministers and their life and work in widely differing parish situations within Scotland. The basic information derived from this initial investigation was further supplemented by documentary evidence from primary sources and by any other research material available at the time.

It may seem that such an investigation, which is primarily sociological in nature, bears little relation to the issue of health and illness which is our principal concern. Although it is an indirect approach to the study of health and illness in the experience of these ministers, it was considered that this preliminary phase was essential if their experience was to be understood. It was expected that this study would establish an extensive, though flexible, framework within which all subsequent information with respect to health and illness could be seen in perspective. It was further expected, particularly in view of the total absence of any previous research in this field, that such information would at least serve to pose tentative questions in regard to the well-being of this group of ministers. Moreover, it was considered that such a study would serve to correct any uninformed opinions or stereotypes which the investigator might hold about the kind of life in which Church of Scotland ministers are engaged. It is all too easy to assume, for example, that the ministry is a "sedentary occupation", or that the minister "only works one day a week", or that the minister is economically secure "because he doesn't have to work". None of these stereotypes, or any others, were to be taken into account in the investigation.

For these reasons it was decided to undertake a preliminary inquiry, based on the life and work of four parish ministers, into the minister's world.

(2) Empirical Data: Mortality and Morbidity

Against this background, a diagnostic inquiry seeks to establish, in precise terms, the nature of the person's complaint: What is the presenting problem and what are the accompanying symptoms? Before seeking to discover the historical causes behind the person's condition, it is first necessary to clarify the presenting problem.

Following this procedure, the second phase of this project was designed to establish a precise, empirical foundation of health and illness in the experience of this group of ministers. This phase takes the form of a formal statistical study of mortality and morbidity in the experience of Church of Scotland ministers between 1930 and 1969. It is based on the assumption that phenomena associated with mortality and morbidity, in terms of life expectation, rate of death, causes of death, and the rate and causes of morbidity and disablement, provide sensitive indices of a group's health. Such information also provides a basis of comparison with other occupational groups and may also yield information or clues to the peculiar health hazards to which a particular group are exposed. Therefore, in terms of mortality and morbidity, the second phase of this project asks: What are the effects of being a Church of Scotland minister? how long do they live? what do they die of? how frequently are they disabled? what have been the causes? have there been any changes in these phenomena? does such information expose any peculiar occupational health hazards to which they are exposed? and so on.

However, while such statistical information is necessary in acquiring a complete picture of a community's health, it has no intrinsic value in itself. In a sense, such data could be compared with the presenting problem in a therapeutic situation. Mortality and morbidity data is purely symptomatic and only has value in so far as it provides insight

into the total pattern of experiences and processes which underlie the symptoms. As symptomatic material it requires interpretation. Furthermore vital statistics are the product and reflection of the sum total of individual, personal experience. Behind the statistics there are persons, and this inquiry is chiefly concerned with experience of parish ministers as persons. Nevertheless, it was expected that this statistical phase would provide a necessary and valuable foundation of empirical data.

(3) Personal Experience

A diagnostic inquiry then moves on to consider the patterns of experience and historical causes which lie behind the external phenomena: What more can be known of the experiences and processes behind the complaint and symptoms expressed and manifested by this person? The investigator probes behind the symptoms to clarify the nature of the complaint and to discover whether the presenting problem disguises or conceals a more basic, as yet undisclosed, disorder.

The third phase of this project, likewise, was designed to move into the personal and inner realm of ministers' experience to uncover the historical processes and themes associated with their experience of health and illness. Attention would be focussed on individual ministers and their personal experience with respect to health and illness. This phase of the inquiry takes the form of a personal survey of a representative sample of Church of Scotland ministers employing a standardized interview-questionnaire structure. The two preceding phases are chiefly concerned with externals: the external features of the minister's world and the external symptoms of health and illness as they appear in mortality and morbidity data. But this phase constitutes an attempt to penetrate and appreciate the inner realm of personal experience.

The interviewing procedure which was constructed for this purpose was standardized and was designed to elicit specific information with

reference to the physical, intrapersonal, interpersonal, and transcendent dimensions of individual ministers' experience of health and illness. It was also designed, however, to allow sufficient freedom for a wide range of responses and for freedom of expression and aimed to focus attention on the subject's personal experience. The structure was sufficiently 'open' to facilitate personal exchange and interaction between the interviewer and the interviewee and to provide a basis for inter-experience. By employing a structured-interview method, which necessitates encounter and participation, it was hoped that access and insight could be gained into the personal experience of Church of Scotland parish ministers which would uncover and illuminate their experiences of health and illness.

This is a simplified introduction to the three phase programme adopted for the purposes of this study. The basic purpose was to undertake a diagnostic inquiry, a fact-finding investigation, into the health of Church of Scotland ministers between 1930 and 1969. The methodological structure employed for this purpose was based on the assumptions of existential analysis and was constructed on the analogy of a diagnostic interview, rather than employing a formal experimental design. The details of the procedure employed in each phase will be elaborated as the discussion proceeds.

The intention behind this methodological structure was to probe progressively deeper into Church of Scotland ministers' experience of health and illness through a process of progressive discovery. Each unit approaches health from a different perspective and each could stand as self-contained studies; at the same time, however, they serve to illuminate different facets of the same problem and should be seen in juxtaposition. These phases were intended to complement and supplement one another in order to provide a comprehensive picture of health and illness in the experience of this group of ministers.

In order to construct the total pattern of experiences associated with health and illness, the methodology is unabashedly eclectic and interdisciplinary. As suggested earlier, it was considered that only a multilateral method of discovery could gain access to experiences of health and illness in all their dimensions and variety.

Finally, it was not expected that this study would be exhaustive. In fact it was fully expected that this project would eventually pose more problems than it would solve. However, in view of the absence of prior research in this field, it was considered that the top priority was for a comprehensive, macroscopic study of the kind proposed here even though this would inevitably reduce the degree of precision and would restrict the conclusions which could be drawn from the accumulated evidence. It was hoped that an initial study of this kind would open the way to a continuing process of discovery in this field and would provide a base-line from which more detailed, microscopic inquiries could be conducted in the future.

PART II

THE MINISTER'S WORLD

- CHAPTER 5. THE PAROCHIAL REALM.
CHAPTER 6. THE FUNCTIONAL REALM.
CHAPTER 7. THE PERSONAL REALM.

CONCLUSION.

CHAPTER 5

THE PAROCHIAL REALM

INTRODUCTION

"The Church of Scotland's first responsibility is to maintain religious ordinances throughout the land. This responsibility is discharged by means of a settled parochial ministry."⁽¹⁾

This statement, repeated annually in the Church of Scotland's Year Book, expresses a basic tenet of this Church's ecclesiastical strategy. As the national church,⁽²⁾ the Church of Scotland has a particular responsibility for establishing and maintaining the Christian faith throughout the nation which is achieved, primarily, by gathering local communities or congregations whose purpose it is to worship, to foster fellowship, to bear witness, and to serve the surrounding community or 'parish'. The Ministers of the Church of Scotland are, for the most part, deployed throughout this parochial system and these parish ministers have the task of gathering, instructing, and guiding the local congregations for their ministry to the wider community. It is within this milieu of a parochial and congregational structure that Church of Scotland parish ministers have their place.

The parochial system, based on a "territorial principle",⁽³⁾ is considered to be indispensable for the over-all ministry of the Church of Scotland and the primacy of the parish ministry in the Kirk's strategy

(1) The Church of Scotland Year Book, 1932, p. 28.

(2) In the Union of Parliaments in 1707, the Church of Scotland was assured its national status, together with Scottish Law and Judicial system, by an Act for Securing the Protestant Religion and Presbyterian Church Government.

(3) Reports to the G.A., 1945, p. 565.

has been frequently reasserted by its Courts and administrative bodies. A parish minister is responsible for the care of a reasonably small, precisely delineated parish which, ecclesiastically speaking, is his exclusive territory:

"A minister's field of ministerial work and responsibility lies within and does not extend beyond his own parish. A minister shall not be at liberty to overstep his own bounds."⁽¹⁾

Depending upon the size and needs of his congregation and parish, he may be assisted by a student for the ministry, a Probationer Assistant, or by a Deaconess, and he may obtain secretarial assistance. But it is in essence a one-man parish ministry which emphasises a strong personal and pastoral identification of the minister with a specific parish.

The parish system, extending throughout Scotland, is governed by a Presbyterian Form of Church Government.⁽²⁾ That is to say, authority is invested in Presbyteries, which are corporate representations of a collection of regional congregations, by contrast with Episcopal and Congregational systems of government. The Presbytery is an elected body of clergy and laity which, as a corporate 'episcopate', superintends every aspect of the Church's life and work within its territory and it is the central component within a hierarchy of Church Courts from the congregational Kirk Session up to the General Assembly. At every level it is a system which places great stress on the election of office-bearers and representatives, democratic decision-making procedures, and the parity of clergy and laity. In this system, the individual minister is answerable to and under the supervision of the Presbytery to which

(1) Practice and Procedure in the Church of Scotland, op.cit., p. 49.

(2) Ibid., p. 134 ff.

he belongs.⁽¹⁾ Strictly speaking, he is not directly answerable to his particular congregation or even to the Kirk Session, the elected Ruling Elders of his congregation.

There are a variety of non-parochial ministries within the Church of Scotland including specialist chaplaincies (viz. Chaplains to hospitals, the deaf and dumb, industry, universities and other educational institutions), Chaplains to the Armed Forces, academic and educational positions, administrative offices, overseas missionaries, and ministers in Colonial and Continental Charges. Although such ministries have undoubted value and have assumed increasing importance, they are usually regarded as being ancillary and supplementary to the parish ministry. The primacy of the parish ministry has been protected, in effect, by the general procedure associated with Ordination. Even though it is explicitly stated that Ordination is to the "office of the Holy ministry",⁽²⁾ not to a particular form of ministry, it usually accompanies induction into a specific pastoral charge within the parish system.⁽³⁾ It is therefore usually required that a man should gain some parish experience before embarking on a specialization. There are few exceptions. This means that it is virtually a condition of Ordination that a candidate enter the parish ministry at least initially.

Although there has been growing emphasis on 'specialist' ministries, the parish ministry is still regarded as primary and absorbs the bulk of

(1) Practice and Procedure, op.cit., p. 145.

(2) Ibid., p. 566.

(3) Ibid., p. 250 ff. The only regular exceptions have been Professors in Theological Colleges and Faculties of Divinity and also Ordained Missionaries. More recently (since 1954), exceptions have been made for Chaplains to the Deaf and Dumb. Other exceptions are made but they are infrequent and only "when expressly authorised by the General Assembly or its Commission" (Ibid.). Also see Reports to the G.A., 1969, p. 12.

the Kirk's ministerial manpower. An indication of the deployment of the Church of Scotland's ministerial resources is provided by Table 2 (over). In 1939 there were 2,409 parish ministers, that 89.2 percent of the total active manpower. The total number of active parish ministers had fallen to 1,827 by 1968, which represented 88.0 percent of all those actively engaged in the service of the Church of Scotland.

In the inquiry reported here we are chiefly concerned with the health experience of Church of Scotland ministers in the period from 1930, immediately following the union of the Church of Scotland and the United Free Church of Scotland, and 1969. In 1930 there were approximately 2,790 parish ministers⁽¹⁾ and a further 3,118 men had been ordained and admitted to the Church of Scotland ministry by the end of 1969. This gives a total population of c. 5,908, most of whom have had experience as parish ministers within Scotland.

The first phase of this project, conducted between November 1967 and May 1968, aimed to identify and describe the outstanding characteristics of the kind of life-style which these ministers share in common and which distinguish them from any other occupational group and from any other group of clergymen. The object was to explore common areas of parish ministers' experience in order to establish the main features of their 'world', to correct any misconceptions or stereotypes which the investigator may have inadvertently acquired, and to construct a broad panorama within which their experiences of health and illness could be seen in context. We shall not be so concerned with the legal and procedural minutia which govern the minister's place in the Church

(1) There is no record in official documents of the exact number of parish ministers in 1930 and this figure, calculated from the 1930 Year Book, is approximate. There were certainly no fewer than this number.

TABLE 2 . DEPLOYMENT OF THE CHURCH OF SCOTLAND MANPOWER , 1930-1969.

SERVING OTHER PRESBYTERIAN CHURCHES	45	44	56	61	106	131	120	—	—
UNATTACHED	156	138	118	109	119	111	132	150	164
FINAL YEAR STUDENTS	.	.	100+	43	89	46	56	50	57
PROBATIONERS	103	92	205	86 (61)	89 (54)	87 (32)	(25)	143 (19)	125 (9)
TOTAL NON- PAROCHIAL	52	54	78	80	96	96	100	110	125
MISCELLANEOUS	.	.	7	5	13	11	15	16	24
INDUSTRIAL CHAPLAINS	.	.	—	—	1	1	1	2	4
UNIVERSITY CHAPLAINS	.	.	2	3	5	5	6	8	12
ACADEMIC POSITIONS	.	.	36	32	36	36	38	41	45
CHAPLAINS TO DEAF/DUMB	.	.	1	5	5	6	7	6	5
HOSPITAL CHAPLAINS	.	.	8	7	8	8	8	9	9
ADMINISTRA- TIVE OFFICES	.	.	24	28	28	29	25	28	26
CHAPLAINS TO H.M. FORCES	16	17	24	143	46	47	38	36	32
COLONIAL & CONTINENTAL	(51)	(49)	192	156	145	101	(51)	108	93
VACANT CHARGES	(108)	(102)	129	164	130	200	165	131	100
PARISH MINISTERS	c. 2,790.	c. 2,500	2,409	2,246	2,210	2,080	1,928	1,885	1,827
CHARGES	2,898	2,602	2,538	2,410	2,340	2,280	2,093	2,016	1,927
YEAR	1930	1935	1939	1946	1951	1956	1961	1965	1968

(NOTE : FIGURES FOR NON-PAROCHIAL MINISTRIES ARE ESTIMATES DERIVED FROM LISTS OF CLERGY
PUBLISHED IN THE CHURCH OF SCOTLAND YEAR BOOK.)

and society,⁽¹⁾ but rather with those aspects of their experience which are of most immediate importance to ministers themselves and of which they are most aware.

PROCEDURE AND SOURCES OF INFORMATION

In conducting this initial background-study attention was focussed on the life and work of four parish ministers. To avoid bias, they were selected by an independent judge, who was not aware that they were to be used for this purpose,⁽²⁾ and the investigator had no previous acquaintance with any of them. They were selected to represent men of varying backgrounds and experience and to represent markedly contrasting parish situations.

The investigator had to rely upon information elicited directly from these four ministers. In the Church of Scotland the minister has a large measure of autonomy and, although he is answerable to his Presbytery for the conduct of his ministry, he is under no direct

- (1) The reader who wishes to familiarize himself with the ministry in the Church of Scotland in greater detail should consult Practice and Procedure in the Church of Scotland (especially Chapters IV, X - XIII, XV), op.cit., Compendium of the Laws of the Church of Scotland (2nd Edition, 1937), and the Church of Scotland Year Book for procedural details. G. Donaldson, The Scottish Reformation (Cam. Uni. Press, 1960) provides a valuable historical perspective. A panoramic sociological survey is presented by J. Hight, The Churches in Scotland Today (Jackson, 1950), while J. Littlejohn, Westrigg: The Sociology of a Cheviot Parish (London, 1963) is an outstanding example of a microscopic sociological study of a particular parish. A highly personal account of experience as a Scottish parish minister is presented by J.W. Stevenson, God in My Unbelief (Collins, 1960).
- (2) These four men were initially invited to act as Honorary Lecturers in a course on "Church and Society" for third year theological students at New College, Edinburgh, and were subsequently asked to participate in this particular study.

supervision except in unusual circumstances.⁽¹⁾ To all intents and purposes he is his own manager and supervisor and only he can be in possession of all the facts related to his work and personal life. It is therefore inevitable that the individual minister is the major source of information and an investigator is dependent upon the veracity, reliability, and objectivity of the minister's self-disclosures.

Data was derived from five main sources:

- (i) one-hour lectures delivered by each of the informants to final year theological students on the minister's role in particular parochial environments;
- (ii) one-hour seminars on the nature of the parish ministry led by each of these ministers;
- (iii) written statements prepared by each informant on the geographical and socio-cultural characteristics of their parishes;
- (iv) two interviews, each approximately an hour in duration, with each informant;
- (v) and daily work-records for one month (April 1968) supplied by the informants.

The collected data was expanded and supplemented with information contained in documentary sources, such as the Church of Scotland Year Book, Reports to the General Assembly, the manual of Practice and Procedure in the Church of Scotland, the *Fasti Ecclesiae Scoticae*, and the reports of the Registrar General for Scotland. Research conducted elsewhere provided further information and a basis for

(1) Practice and Procedure, op.cit., pp. 145, 158, 179.

comparison.⁽¹⁾

Before proceeding with this inquiry into the minister's 'world', two qualifications should be offered. First, it was recognized that caution should be exercised in basing sweeping generalizations on the experience of only four parish ministers out of a total population of 1,827 at the time of the inquiry. Such information was bound to be misleading, and highly personal, in some respects and inadequate in others. Care was taken to corroborate and supplement their information as far as possible from documentary and research sources.

In the second place, it would have been valuable to consider the minister's life and work from the perspective of others, such as their wives, Elders, or parishioners. In particular, 'parishioner expectations' and attitudes as they are perceived by ministers assumed increasing significance as this project progressed. However, some limits had to be established and it was not feasible to enter this area of inquiry. The following discussion therefore considers the minister's 'world' purely in terms of ministers' own expectations and perception. With a view to the future, a study of 'parishioner expectations'⁽²⁾ in the Church of Scotland would be a valuable undertaking and could, incidentally, have relevance for the health of ministers.

(1) For example, reference was made to B. Anderson (1969), op.cit., J. Highet (1950), op.cit.; J. Littlejohn (1963), op.cit. Valuable supplementary and comparative information was also obtained from K.A. Busia, Urban Churches in Britain (Lutterworth, 1966); R.H.T. Thomson, The Church's Understanding of Itself (S.C.M. 1957); D. Martin, A Sociology of English Religion (Heinemann, 1967); M. Weber (1922), The Sociology of Religion (Methuen, 1965); and the outstanding series of studies conducted by S.W. Blizzard.

(2) As has been done, for example, in other contexts by S.W. Blizzard (1956, a; 1958, a); L.L. Falk (1963); and R.H.T. Thomson (1957).

FOUR MINISTERS AND THEIR PARISHES

In terms of their backgrounds, Church of Scotland ministers represent a broad cross-section of the Scottish population. Some of the more typical background characteristics will be considered at a later stage,⁽¹⁾ but, in general, they are drawn from all sections of the Scottish community and have diverse family, socio-economic, educational, and occupational origins, as is illustrated by four participants in this inquiry. At the outset all that they have in common as individuals is their vocation, their religious "calling". Having recognized and expressed their sense of vocation, they then pass through the selection and training procedures of the Church of Scotland, usually extending over six years with a further probationary year, and, for the most part, become engaged in the parish ministry. Our attention now turns to the parochial realm of their experience.

PARISH A: RURAL LINKED-PARISH

The first of these ministers, to whom we will refer as Minister A, is a man in his mid-50s and entered the ministry shortly before the last World War. His family has a middle-class, professional background. Minister A was ordained following a distinguished academic career, which included a period of post-graduate study in the United States, and he had no previous occupational experience. He has had considerable parish experience and has held four pastoral charges over a period of almost thirty years. His previous parish experience has been varied, a rural linked-parish, a small town in the Southern Highlands, and a mining-industrial town in the West, and he has been in his present rural linked-parish for eight years. His experience also includes a period of three

(1) Part IV: Chapter 12.

years as a Chaplain to the Armed Forces during the war. (1)

Minister A married shortly before his ordination and induction to his first charge. He has two children, both of whom are now adults no longer living at home, and he is a grandfather.

As a person, he appears to be reserved and reticent, if not reluctant, to impart information concerning himself or his ministry. He was certainly less willing to provide information than his colleagues, as we shall see.

Minister A's present parish comprises an agricultural community, based around three villages, with a small resident population dispersed over twelve square miles. Up until 1928 it constituted two separate ecclesiastical parishes which were then "linked" and have been served conjointly by one minister since then. Minister A provided the following description of his parish and congregation. (2)

PARISH A

"A. The Ecclesiastical Parish

This ecclesiastical parish was brought into existence by the General Assembly of 1928, which enacted that the parish of X—— should be annexed to the parish of Y——. These two parishes had for a short time after the Reformation been served by the same minister; but apart from that the churches in X—— and in Y—— had followed their separate existence since their foundation about the middle of the thirteenth century. The present union has had time by now to settle down and become an established fact; and although each church building has retained its own group of worshippers there is no sense of their being two separate congregations. (X—— and Y—— do of course continue their separate existence as civil parishes; and

- (1) All personal and statistical data with respect to these ministers and their parishes refers to the position in January 1968.
- (2) Strict confidentiality was not a condition of this study, but in order to preserve a measure of anonymity for the informants their statements have been slightly modified. However, it is not unlikely that anyone thoroughly acquainted with the Church of Scotland could probably identify each of these men from the facts presented here..

for that reason, they are separately dealt with in the notes from official records and statistics that follow, in sections B and C of this outline.)

The Congregation Today: The Roll of Communicants contains approximately 370 names - that figure averages the past five years; about thirty of these are "members away". Church attendance varies greatly; sometimes because of the season of the year, at other times for less obvious reasons. Even at its best, it could be much better. Numbers at the communions (held quarterly) show an increase over other Sundays; but they are not as great - so it is said - as in the days of the half-yearly communion. Services are held at 10.45 a.m. in one church, and at 12 noon in the other; there is no regular evening service.

The congregation is very representative of the population of the parish - all "ranks of society" being included. It does not include many people from the "professional middle class" and this may be reckoned a weakness, which shows in e.g. the make-up of the Kirk Session.

There are two Sunday schools in the parish - one at each church. At X—, the Sunday school meets concurrently with the church service; and at Y—, just before it. The former has an attendance of 9 or 10; the latter varies considerably, the total number on the roll being about twenty.

Arrangements for Bible Class activities are not easy to make in a satisfactory form, and different expedients are still being tried out.

There is no congregational Youth Fellowship but one or two of the young people attend the fellowship in a local town.

The Woman's Guild meets once or twice in the month, depending on the season. The same cause operates to help decide whether meetings should bring all the members together or simply those in one "end of the parish".

B. The Civil Parish of X—

(i) Nature and Size: An agricultural parish, of 3106 acres in area; X— has no village, no railway station, no shop, no post office, no public house, and no police station. Within its bounds lie eight farms, and portions of several large estates. The kirkton of X— is the nearest thing the parish has to a centre of population; and here there are the church, the school, the public hall, a sizeable dwelling house (once the manse), a farmhouse and steading, a few cottages, and half a dozen "Orlit" type houses.

(ii) Population: At the last census (1961) there were 209 in the parish - 102 males and 107 females; this was a decrease of thirty since the 1951 census. A century earlier, the figures were: in 1861, a total of 332; in 1851, a total of 373. Thus in 110 years the parish lost approximately 44% of its population; the county as a whole shows over the same period an increase of roughly the same percentage - from 36,386 (1851) to 52,677 (1961).

(iii) Schooling: The one-teacher school at the kirkton provides primary education for children within the parish. The number presently attending the school is 8. Seven years ago it was 24.

For their secondary education the pupils go mainly to the nearest town; but in most years there is at least one child in the primary school who is going on either to boarding school or to day school in Edinburgh.

(iv) Work and Recreation: Farm and estate work, not always within the parish - factories and offices in the nearest town or further afield - these account for the main employments both of men and women at work.

The readiness, and in some cases the necessity, to go outside the parish for work is matched by a similar willingness to travel in search of entertainment - this is particularly true of the younger people. The local Youth Club has had a very chequered existence; but there is a flourishing Recreation Club for the men, and an enthusiastic branch of the W.R.I. All these meet in the Public Hall.

(v) Transport and Shopping: A good service of vans and mobile shops brings most of the daily necessities of life to the cottage door; for anything beyond this, it is necessary to go to the nearest town, some two miles away. There is a two-hourly bus service; but many people will walk on and let the bus catch them up, rather than wait for it. Many more people than formerly have their own private transport.

(vi) Welfare and Public Services: There is neither doctor nor district nurse resident within the parish. The nurse is stationed in the neighbouring parish of N——; and doctors come in the main from the nearest town, where there are also the nearest hospital services. Matters of public welfare and assistance are dealt with by the District Council through its Clerk, who is helpful and understanding.

A social Club organised in N—— by the W.V.S. for the benefit of old age pensioners has recently opened its doors to pensioners from neighbouring parishes. Transport is provided by W.V.S. members.

C. The Civil Parish of Y——

(i) Nature and Size: A rural, mainly agricultural parish, of 3811 acres, Y—— has two "centres of population" - the villages of East and West Y——. The former is the larger of the two, and contains some sixty houses, two shops, a service station and a smithy. Church, manse, and school are all situated here; and East Y—— has been for some years now a growing community.

By contrast, West Y——, with its nine or ten houses and single shop, is a mere shadow of its former self; and though one or two houses have been built in it recently by private individuals, there seems little prospect for it of any further growth.

Besides these two villages the parish includes a dozen farms and two sawmills. Until recently there was also a limeworks, the estate of Y——, which formerly took in both villages and most of the farms; has been gradually sold off during the years, and now retains only two of the farms and one or two houses in the village, as well as the mansionhouse itself. This is now completely empty, the 'laird' using a converted cottage on the estate for his brief and infrequent visits.

(ii) Population: At the last census, the total was 353 - almost the same as ten years earlier, when it was 355. In 1861 the total was 712; and in 1851 it was 697. Thus in 110 years the population of the parish had decreased by just under 50%.

(iii) Schooling: The two teacher school at East Y—— provided primary education for 30 to 40 children - the number has varied over the past seven years. Thereafter the children go on to the nearest town; or, very occasionally, to a school in Edinburgh.

(iv) Work and Recreation: What has already been said of X—— applies generally here, except that Y—— sends workers regularly into Edinburgh. Recreation 'on the spot' is provided for the womenfolk by the W.R.I.; and some of the older people go to a Pensioners' Club in a neighbouring village.

(v) Transport and Shopping: The two local shops are of a general nature - one includes a Sub-post-office. There is a very good service by van etc. People who travel for their shopping may go to one of the nearer towns.

(vi) Welfare and Public Services: Medical services are provided by doctors from various nearby towns. The district nurse is stationed in a neighbouring village. Otherwise the information given for X—— holds good."

The picture is one of a sparsely populated farming community which has suffered the effects of progressive depopulation since 1851. The parish has no integrating, focal point of community life, it has few local amenities, offers limited opportunities for work, lacks young families and has no professional middle-class. The congregations in the two main villages represent almost two-thirds of the local population.

PARISH B: COUNTRY TOWN

Minister B, likewise, has considerable parish experience extending over more than thirty years. His father was a railway clerk and he is one of three brothers. The family has made an outstanding contribution to the life of the Church in a variety of ways. Minister B was himself

ordained in the mid-1930s at a comparatively youthful age, having proceeded from school to university and so into the ministry. Since then he has held five extremely varied charges, including three country towns, a large provincial town, and suburban residential parish, spending an average of six and a half years in each. In addition to his parish responsibilities he also held the posts of Presbytery Clerk and convener of a major General Assembly Committee at the time of the inquiry.⁽¹⁾

He married a school teacher eight years after his ordination, when he was in his second parish, and they have a young daughter. Minister B's wife uses her educational skills to contribute to the life of the congregation but has not engaged in her profession since their marriage.

Despite his demanding programme, involving his parish, the Presbytery, and the General Assembly, Minister B readily agreed to contribute to this investigation. He was always forthright and helpful in lectures, group discussions, and personal interviews, his material was well-prepared and his responses thoughtful. He conveyed the impression of meticulous organization and of being in command of his work.

As far as his present parish is concerned, which he has held for seven years, Minister B provided a simple summary of its basic characteristics.

PARISH B

"Size and Situation"

The parish is about 20 square miles in extent, and is centred on a small Scottish border town on the river Tweed. It is situated at its centre some 30 miles south of Edinburgh.

- (1) Tragically, Minister B died suddenly and quite unexpectedly as the result of a major cerebral haemorrhage within a year of this inquiry. An obituary in Life and Work questioned how one man could fulfil so many demanding responsibilities, it paid tribute to his "self-discipline, hard work, and devotion to duty", and also observed that "his people loved him for his modesty, complete dependability, and the sheer honesty of his concern for their welfare". It was a fitting tribute but it also posed crucial questions with respect to health and the ministry.

Population

The population of the parish is approximately 2,500 of which 2,252 comprises the population of the burgh town. There is a good spread of population, the main shortage occurring in the 17-25 age range when many leave the district to find work or professions elsewhere.

Nature of the Parish

Of the twenty square miles that comprise the parish, by far the larger part consists of hills and bare slopes and boulder-strewn valleys. The arable land is small, and most of the area is used for breeding and rearing sheep. Some forestry now takes place.

Largely this is a rural parish, but it has a small industrial town, which holds most of the parish population. The inhabitants are employed mainly in three spinning mills, and a hosiery mill.

The mill came to B—— first in 1788 by the generosity of a certain Alexander Brodie, of Carey Street, London. Native of the parish of Traquair, who had made a fortune by inventing the 'closed stove', he wished to provide employment in the winter-time for the poor people of B—— and built a five-storied mill. (It still stands). This industry has grown and become the mainstay of the community.

History

The first mention in history of B——, so far as I know, was in connection with its Church. In 1159 King Malcolm the Maiden granted to the monks of Kelso the Church of B—— with all its rights, and because the body of his son, who had been drowned in the River Tweed, was cared for in the Church, he assigned the Church of B—— the right of refuge or sanctuary. Very few Churches in the Borders had this right.

This area of Tweedside was the holiday area of the Kings of Scotland and so there built up in the area a very strong feudal sense. A growth of paternalism has also been seen through the presence still in the mills of the local owners - the Ballantyne family.

The Church

The Church of the Parish is a union of Free Church, U.P. Church and Old Parish. In 1962 the Congregational Church closed and some 40 members joined the Parish Church.

There is a small Scottish Episcopal Church which is cared for by a retired priest. They have a membership of about 30.

There is a striking Roman Catholic Church in the centre of the town, built in 1879 by the then Earl Traquair in memory of his wife. There are about 100 communicants here.

Plymouth Brethren have a small meeting in the town.

Parish Church membership in 1831 was 264 and the population 810. Membership today is 1,203; population is 2,500.

Education

St. R——'s School built in 1957 has both Primary and Junior Secondary Departments, is a most up-to-date building.

The School for Mentally handicapped children from the whole County of Peebles is in the Parish.

High School is at Peebles.

Amenities

Public Library managed by a local Committee.
Amateur Operatic Society.
Camera Club.

Social Services

Medical Officer of Health is for Midlothian and Peebles.
District Nurse and Health Visitor.
Welfare Officer for the County.
Mental Welfare Officer for County (same person as above).
Hospitals: General Hospital - Peel Hospital, Galashiels
War Memorial Hospital, Peebles
Maternity Hospital, Peebles
 Serious cases to Edinburgh.
Old People's Home, Peebles
Two Doctors resident in B——
Welfare Service Office - Galashiels
W.V.S. Meals on Wheels Service
W.V.S. Chiropody Service
W.V.S. Hospital Car Service."

This outline was filled-out in further discussion with Minister B.

The parish is centred on a burgh town which is a self-contained and self-supporting community with all necessary amenities readily available.

The town supports several small-scale secondary industries, which have strong family and paternalistic traditions and which offer the main source of employment. The population represents a heterogeneous cross-section of social classes, and the main lack is in the 17-25 age group as young people are drawn to Edinburgh for education, entertainment, and employment. The parish includes 20 square miles of pastoral and agricultural land surrounding the town. This area has a number of large estates, with a feudal background, and has a population around 250. The Parish Kirk has a membership of 1,220 which represents 50 percent of the local population.

PARISH C: SUBURBAN RESIDENTIAL

Minister C is the youngest and most recently ordained of these four ministers. He is the only son of an accountant, and he entered the ministry following war-time service with the R.N. and was ordained in the early 1950s. His first parish was a rural-mining village community in Fife and he is now in his second parish where he has served for eight years.

He was married prior to ordination, while still a Probationer, and has a family of three ranging from thirteen to two years of age. His wife was also a teacher and has not worked since their marriage.

As a person, Minister C is open and responsive in personal relationships and conveys an impression of self-assurance and friendliness. He agreed to participate without hesitation and proved to be an articulate informant. Despite his outward self-assurance, he tends to be facetiously self-critical and is very conscious of personal inadequacies.

His parish, in one of Scotland's major cities, is suburban-residential in character but has undergone appreciable changes in the post-war period. He provided this brief summation of its principal features.

PARISH C

"Suburban Church in a mainly residential community, but not one-class or one-type. Parish of about 1,064 homes with estimated resident population of 2,200 adults with considerable non-permanent (especially student) additions. Housing ranges from low quality tenements through flats, villa'd rows to high-grade detached and semi-detached houses. Increasing sub-division of larger houses for speculative sale and for letting. Steady encroachment of University for staff houses and student hostels, and (on main roads) of private hotels and B. and B. establishments. Population at one time settled and on average fairly affluent, now much less settled, more young families, less affluence. Cross section of employment - university staff, business and professional people, retired folk, and minority of artisan and industrial workers. Great majority work outside parish. Parish includes two-three industrial concerns, school for mentally handicapped children (close link with church - minister is chaplain). R.C. Church (cordial relations), Baptist Church (virtually no contact).

Church History

V—— Free Church founded on present site in 1875 to cater for expansion of city to the south, became V—— United Free Church (1900), V—— North Church (1929). 6 ministers up to 1958.

W—— Secession Church (1828), W—— United Presbyterian Church (1847), moved to I—— United Presbyterian Church (1856) and thence to site in F—— Road Church (1929). 5 ministers from 1830 to 1956.

These two congregations were united in 1958 as V—— and W—— Church. Present congregation about 1,020 communicants of whom 307 live within the parish. Congregation scattered throughout city with greatest density nearest to the church. More distant members encouraged to disjoin but not obliged to.

Congregational emphases

Parish responsibility - fairly highly developed. Parish Register of all homes. Incomers visited. Christmas Card to every home in parish. Coffee after morning services. Old People's Club weekly (mem. 70), Youth Club (Sat. evenings, mem. 130). Abbeyfield House sponsored and supported by congregation.

Worship - limitless willingness to explore new forms; intelligent interest in preaching (!)

Organisations - Woman's Guild - Young Mothers' Circle - Study Groups - daily intercessory groups - prayer services for the sick.

Youth - Sunday School (material prepared by local committee) Boys Clubs (13/13, 15/17), Youth Fellowship, Scouts, Guides, Boys Brigade (in Mission Hall, Gifford Park).

Recreational - Dramatic Club, Country Dancing, Golf Club, Badminton, Garden Club, etc.

Stewardship - Services looked for from all members. Finance highly organised - highest presbytery assessment per head for co-ordinated appeal - 40% of income set apart for non-congregational purposes.

Problems: The proper function of a congregation in this situation.
The relevance of the parish in this situation.
'Stretching' and using to the full the potentialities of members.

Over a period of twenty-five years this parish has undergone gradual but marked social changes. Prior to the war it was a homogeneous, middle-class, residential suburb which enjoyed a measure of affluence. It has retained a basic core of settled middle-class residents but, as Minister C notes, the community is now much less settled, has a higher proportion of young families, and is less affluent. Many former residents have

moved to more 'attractive' suburbs and with the subdivision of larger houses and the development of numerous hotels, hostels, and "Bed and Breakfast" establishments the population has grown and has a higher proportion of 'floating' residents. Many of these are University students and staff-members.

The congregation shows two interesting contrasts to those of Ministers A and B. By contrast, for instance, this congregation has a strong 'Free' Church tradition and background. It eventually emerged out of successive unions between various 'free' congregations, within the United Presbyterian and United Free Churches. Secondly, a large proportion of members are gathered from beyond the parish itself and the congregation is scattered over a wide area. Indeed only 30 per cent of the membership (307:1,020) resides within the parish. This would suggest that the parish boundaries are completely artificial and coincide with no real sense of community. It is also indicative of the difficulty if not impossibility of maintaining strict parish boundaries in an urban environment.

PARISH D: NEW HOUSING DEVELOPMENT

Minister D was ordained shortly after the war, a few years before his colleague Minister C, following wartime service with the R.A.F. He is a "son of the Manse", as is not uncommon in the Church of Scotland, and is one of four brothers in a family which has made a notable contribution to the life and work of the Kirk. The family has a strong tradition of "sons in the ministry". Minister D has been actively engaged in the ministry for almost twenty years and has now served in this his second parish for ten years. He is in fact its first minister.

He was married shortly after ordination and has a young family of four children, from sixteen to six years of age. His wife is a teacher

and worked for a short period following their marriage until the arrival of their first child. She has seriously considered the possibility of returning to her professional work once their younger children are more self-reliant.

Although he seems to be a quiet, reserved person who experiences some difficulty in freely expressing his attitudes and opinions and who does not readily expose his feelings, Minister D had no hesitation in participating. Like Minister B, the preparation of his material was meticulous and he went to some trouble to provide appropriate and adequate information, and he proved to be a valuable and co-operative informant.

Minister D's parish comprises a new housing development scheme on the perimeter of Edinburgh and has been continually expanding over a period of ten years. In terms of total population, his parish is considerably larger than any of the others and at the time of the inquiry had an estimated population of 7,000 with numerous young families. Minister D provided this detailed description of his parish and its development.

PARISH D

"Position and Housing Situation"

D—— Parish is a new housing area, situated on the foothills of the Pentlands. It was instituted as a Church of Scotland parish in 1957, at which time some 550 new houses had been built and occupied within the previous 18 months. Since then about a thousand homes have been built, mostly within a five year period. Apart from three groups of 50 "self-build" houses, 85 army houses and a few private houses on the perimeter of the parish, the houses are owned by the Corporation. The parish, which is compactly placed on a hillside with a pleasant view over the city, is estimated to have a population of seven thousand.

Work

The families housed by this new Corporation housing area come from all over the city, nor is there any one predominant occupation as there is no factory or works near by. There are men in practically every

unskilled and semi-skilled occupation, with many in the local transport and railways. There are no professional or university trained people except the minister and one doctor. But many of the men hold responsible jobs of the artisan type (foremen, etc.), and there are a few policemen housed in the parish. As the families grow up, there are an increasing number of the women working in domestic and servicing jobs for which there is a large demand in the nearby areas. The C—— Hospital and the P—— Hospital draw largely from this area for their domestic staff and some auxiliary nursing.

Families

The average family in the parish consists of a younger married couple with three children (the oldest aged about 10 and the youngest at the baby stage when the parish was first occupied). There are a fair number of larger families. This gives an unbalanced community with large numbers of children, fewer young people in the late 'teens or early twenties, many married adults of the 25-45 age group, few older married people, and about a hundred Old Age Pensioners who are in special Corporation housing. The bulge of youth is gradually moving upwards (in 1967, in the 12-16 age group). Most of the children attend the local Corporation school, about 80% leaving school at 15, with 20% taking senior education, and a few at university and college stage.

Amenities

Apart from the church, there is a large primary school in the parish, a small shopping centre with Post Office, and a small youth and community centre opened in 1967. The parish is fairly well served with transport, there being three regular services and another, peak hour, service. Although there are not many sizeable playing areas in the parish, apart from a small playground there is a large playing field nearby and also there is easy access to the Pentland Hills.

Community Activities

Because of the Church being early on the scene, most of the community activities have been sponsored by the church and still depend for much of their leadership upon church members. Apart from the specifically church organisations, there is a school parents association which is quite lively, an old people's club, and a toddlers' playground, both meeting in the church hall, and another toddlers' playground meeting in the community centre. There is a thriving Pentland Festival, largely backed by the schools and churches. Open youth work pioneered by the church, now meets in the community centre. Tenants' groups have existed, but never strongly.

History of the Parish Church: Street Groups and House Church Groups

Lacking at first any central building, the church began in houses in 1957, and street groups in most streets of the parish were soon formed. These played an important part in initiating and organising church activity and deciding on policy. Although a hut was soon provided and the present buildings (church and hall) opened in September 1958, the street groups continued to play an important part. At one time, as

many as ten groups were meeting monthly during the winter. After five years, these street groups tended to dwindle, but out of them arose a smaller number of house church groups meeting more frequently (fortnightly), much more alive and at a deeper level of fellowship, and not dependent on the minister. At the present, there are four of these house church groups, covering perhaps a fifth of the active membership, with an influence for good on the life of the whole parish out of all proportion to their numbers.

State of the Church in 1967

There are approximately 700 members on the roll, of which about 50 have left the parish and 160 are non-active. This leaves an active membership of about 500, of whom over 300 form an energetic and enthusiastic core. Seven thousand pounds has been repaid to the National Church Extension, leaving less than two thousand still to be repaid, and it is confidently hoped that the church will be self-supporting by 1968. There are about 300 children (up to 11) at Sunday School; 80 at Junior Bible Class; 25 at Senior Bible Class, and 20 at Youth Fellowship. The Women's Guild which is strong and flourishing, contains women of all age groups from early twenties to Old Age Pensioners. All the uniformed organisations exist in varying degrees of strength. Average attendance at worship on Sunday is about 250.

Worship

The approach to worship has been both within the best Reformed tradition, and experimental. The sacrament of Communion is celebrated fortnightly (first Sunday of the month, in the morning, and third Sunday of the month in the evening) with those celebrating coming up and sitting around the table. Baptism is celebrated monthly, and there is a monthly family service. The worship is responsive, the congregation taking an active part. The evening services are used as an opportunity for experiment. An early teaching service during June/September is conducted by members of the congregation.

Fellowship and Service

The strong sense of community is perhaps due to various factors, e.g. the opportunity of a new area, a congregation living within the parish, the influence of house church groups, etc. An active kirk session of 25 elders, meeting monthly, seeks to foster this fellowship and takes an active part in general teaching and in leading communicant classes. There is a strong ecumenical feeling, a D—— Christian Council having been formed with the other churches in the parish, and successful social evenings, acts of worship, and efforts for Christian Aid, etc. have taken place.

Summary

There are all the usual problems of a new housing area - lack of sufficient accommodation, of leadership for youth organisations, etc. But despite this, the parish church seeks and in some ways succeeds in being outward looking, concerned about the welfare of young and old in the parish, and in grasping the opportunities to find a new pattern of congregational life and worship."

This parish is in marked contrast to Minister D's previous parish which was in a small mining town in the South-West of Scotland. However, as a probationer he had two years experience in an equally demanding housing development scheme so he was well prepared to cope with the requirements of such a parish.

Minister D's description of his parish requires little elaboration. However, a number of points are noteworthy. The congregation was established as a Church Extension Charge at the inception of the scheme and although the congregation represents a small proportion of the population (10 percent), it has played a significant part in community developments. By contrast with Minister C's residential suburb, this parish constitutes a relatively homogeneous and identifiable community and in this situation the congregation has found a role and is appreciably more "enthusiastic and energetic" than the other congregations studied with about 40 percent active participation. Moreover, as a new congregation it is free of the social, ecclesiastical, and ministerial traditions evident in the others and the minister and his congregation have been relatively free to determine the nature of their particular ministry. Also, this parish does not involve a 'one-man ministry', strictly speaking. In order to cope with the pastoral needs of such a parish, Minister D is assisted by a Probationer and a Deaconess.

These then are the four ministers and parishes who provided the basis for this initial, background study into the life and work of Church of Scotland parish ministers. The main distinguishing features between them are summarized in the following table.

TABLE 3. FOUR MINISTERS AND PARISHES AND COMPARATIVE DATA*

Comparative Data.	A	B	C	D
Parish Type	Rural Linked - agricultur- al and pastoral	Country town - small industries and rural hinterland	Suburban residential	New Housing development
Parish Population	560	2,500	c. 2,000 adults	c. 7,000+
Ordination/ Age	1938/26	1935/24	1953/29	1949/27
Parish Experience	4th. n.=7.5	5th. n.=6.4	2nd n.=7.5	2nd n.=9.0
- Years in present parish	8 yrs.	7 yrs.	8 yrs.	10 yrs.
Marriage/ Family	m. 29 yrs. 2 children	m. 24 yrs. 1 child	m. 16 yrs. 3 children	m. 18 yrs. 4 children
Stipend (£)	1,100	1,300	1,700	1,080
Communicants	372	1,220	1,020	726
Elders	12	26	65	27
Sunday School	24	180	179	333
Youth Fel'Ship	-	15	180	117
Women's Guild	49	75	95	110
Assistants			Student	Probationer Deaconess

(* Note: These figures apply to the position as at January 1968.
n. = average number of years in each parish since
ordination.)

COMPARATIVE DISCUSSION

Some of the unusual and distinctive features of a Church of
Scotland minister's life and work emerge from these external facts.

1. The Parochial System

The parish minister is personally identified with a particular parochial territory and his ministry is intimately bound up with the conditions and needs of the community in that territory. This is the 'field' of his peculiar responsibilities. But these territories are extremely varied, as is illustrated by these few cases which scarcely do justice to the extent of the variety. These parochial territories range from remote, secluded parishes in the Highlands and Islands to densely-populated industrial complexes in the Glasgow conurbation, from East Coast fishing villages to rapidly developing New Towns in the 'Central Belt', from provincial burgh towns to settled residential suburban areas, from new housing estates on the perimeters of urban areas to ill-defined inner-city areas, each with their distinctive features and problems. The minister's work has to be shaped by the conditions pertaining to his particular 'territory'.

In the context of contemporary socio-cultural change and of changing demographic patterns it is inevitable that some anomalies should occur in this system of one-man parish ministries. Three such anomalies stand out in these particular cases.

In the first place, it is well-nigh impossible to achieve an equitable distribution of available ministerial manpower. It is striking that Minister A is responsible for a parish spread over several square miles with a total population of 560 while Minister D's parish is compact (covering about one square mile) but has a total population in excess of 7,000. The disparity is unmistakable. There are numerous parishes, especially in the Highlands, Islands, and Borders, with resident populations below 500 and, by contrast, there are now many housing development areas and New Towns in which the population exceeds

15,000, in some instances exceeding 20,000. One wonders whether one man, even with assistance, can effectively minister to 15,000 or more people, or even to 7,000 for that matter. One wonders, moreover, whether this glaring disparity in the deployment of manpower throughout the parish system has any bearing on the health of Scottish parish ministers and to what extent the individual minister's health is affected by his particular parish environment.

Secondly, these cases illustrate the extreme difficulty which the Church of Scotland has experienced in adjusting the parochial system to rapid and extensive population movements in this century. This phenomenon has certainly been a major contributory factor to the Church's difficulty in deploying its manpower. Of these parishes, only Parish B has maintained a relatively stable community and has been least affected by population movements. Parish D, as a community, had not come into existence a dozen years ago; it was then no more than a "twinkle in a town-planner's eye". In consequence of major population movements the parochial structure has been subject to a continual process of modification and streamlining with varying degrees of success.⁽¹⁾ In some areas affected by depopulation, as in the case of Parish A, congregations have been linked together to comprise a single parish and in exceptional cases congregations have been dissolved. Following the union of the Church of Scotland and the United Free Church in 1929 a

(1) In 1948 the National Church Extension reported that in this century $3\frac{1}{2}$ million people had moved to new areas in Scotland, presenting a major problem for the structure of the Church (Reports to the G.A., 1948, p. 155). Internal migration continued and by 1951 three-fifths of the population had settled between the Clyde, Forth, and Tay in the Central Belt of Scotland, that is in one-seventh of Scotland's area; many areas had been progressively depopulated since 1861, and new population centres in New Towns and housing schemes developed in the post-war era. The cities were also affected and between 1942-1951 the population of one city ward had fallen by 18% while another had increased by 26%. (Reports to the G.A., 1953, p. 589).

number of congregations in cities and large towns were united, as in the case of Parish C, to avoid duplication. Others have been "transported" to provide the basis of congregations in new areas. Church Extension Charges, like Parish D, have been established in new population centres. In this process, the number of parishes has been reduced from 2,898 in 1930 to 1,919 in 1969, a net reduction of 979 in forty years.

But this streamlining has not produced a more equitable distribution of manpower. Only the external 'structure' of parish boundaries has been changed, not the 'system' of one-man parish ministries. So the anomaly of one man being charged with the care of less than 500 people while another is responsible for 15,000 or more persists.

This is not entirely attributable to the magnitude of the population movements and the difficulties they create. The 'system' itself, based on the principles of Presbyterian Church Government and with its firm adherence to the primacy of the parish ministry, has served to perpetuate this state of affairs. According to the 'system' and the principles implicit in it, the Kirk's administrative bodies and Courts are not at liberty to 'direct' its manpower without the concurrence of the individual minister and any proposal that 'direction' should be employed has been firmly rejected.⁽¹⁾ In consequence, Minister D has sole responsibility for an expanding community of 7,000 people in a compact area while an adjoining established residential area with a similar population spread over three square miles is served by no less than six parish ministers. The discrepancy is blatant and Minister D, not surprisingly, expresses some dissatisfaction at the anomaly. But given the existing 'system' there is no immediate solution.

(1) See, for example, Reports to the G.A., 1947, p. 519; 1950, p. 755; 1965, p. 681 ff.; 1969, p. 720 f.

A third anomaly which appears is that in some circumstances parish boundaries are completely artificial and do not coincide with any recognizable communal entity. This is evident in the case of Parish C, set within a pluralistic urban environment. The other examples are consistent with some kind of identifiable social entities. But this is not true of Minister C's parish. His congregation is drawn from a wide urban area extending well beyond the bounds of his parish and this is true of most congregations in urban complexes, perhaps with the exception of new housing schemes like Minister D's parish. In the same city, for example, one inner-city church has a residential population below 500 but has a membership of more than 3,000. In urban areas and in large burghs and towns parish boundaries are blurred and it is not possible to exercise a 'parish ministry' in the established sense.

These doubts and criticisms concerning the parochial system are not simply an expression of the author's value-judgments. Such doubts and criticisms concerning the viability and efficacy of one-man parish ministries within a precisely delineated parish structure have often been voiced in the General Assembly over the last thirty years. As early as 1942 the Commission for the Interpretation of God's Will in the Present Crisis stated that

"The system of one-man ministries, no matter how faithfully discharged, must be largely ineffective for aggressive evangelism in the populous areas of our country, but has been modified only to a very slight degree".⁽¹⁾

The parish system had been established in Scotland by the end of the Thirteenth Century and it has been the norm of the Church's life for a thousand years.⁽²⁾ In due course, the Scottish Reformers simply retained the parochial

(1) Reports to the G.A., 1942, p. 581.

(2) Reports to the G.A., 1943, p. 458.

system and the established structure and in its essentials, apart from the modification of boundaries, the parish ministry is exactly as it was then. The norms for the ministry established in the 16th and 17th Centuries are still referred to as normative precedents for the life of the contemporary Church in Scotland.

However, the validity, viability, and efficacy of the parochial system as it exists has been in dispute within the Church of Scotland over the last quarter of a Century and its more obvious inadequacies have been recognized and acknowledged in numerous reports.⁽¹⁾ It has been argued that the parish system evolved in the context of homogeneous-self-contained-rural communities, in which it proved effective as a basis for the Church's mission, but it is ineffective and irrelevant in the conditions of pluralistic-urban-industrialized societies. As a corollary, it is argued, the parish structure may still be appropriate in rural areas and small towns, that is in those conditions for which it was designed, but in large towns and urban complexes the parish structure bears no relation to existing social and communal structures. In urban conditions people no longer live in 'parishes' and by maintaining these imaginary geographical divisions the Church in effect detaches itself from society. Even as a means of delineating each minister's area of responsibility these boundaries prove ineffective, as minister's spheres of responsibility inevitably merge and overlap in an urban environment so that the divisions are rendered meaningless. Furthermore, no particular structure or form is essential to the Church's mission as the servant of the Gospel and the servant of the world; no particular structure is indispensable and immutable in the sense of being .

(1) See Reports to the G.A., 1942, p. 581 f; 1943, p. 458 ff; 1947, p. 159, 519; 1950, p. 755; 1953, p. 93; 1965, p. 682; 1968, p. 187, 207-10; 1969, p. 719-21.

"divinely given". Certainly the Church requires some kind of structure, some form of substantial 'body', if it is to be "the body of Christ". But in the condition of contemporary society this form needs to be flexible and adaptable, it needs "to grow around the shapes of worldly need"⁽¹⁾, and the only consideration as to whether a particular structure should be preserved is whether it will aid or impede the mission of the Church.⁽²⁾

The content of these and many other criticisms of the parochial system in the Church of Scotland is not our immediate concern. What is of particular interest are the feelings of dissatisfaction, futility, and frustration which these criticisms apparently reflect. The parish, which has been the norm for the Church's ministry over a thousand years and within which the minister has been assured of a role and status, has become a fragile structure and the implications for the health of ministers are obvious. It has been suggested that attempts to maintain a traditional pattern of ministry derived from a rural culture in the radically altered conditions of urban societies is not only futile and unproductive, but may also be a prominent source of personal difficulties experienced by contemporary ministers.⁽³⁾

From the evidence it would appear that the attitude of Scottish ministers to the parish system is generally ambivalent. On one hand, there is obvious discontent with the system's inadequacies; but, on the other hand, it also seems clear that there is a reluctance to undertake any radical re-formation of the structure or perhaps the system itself has a built-in resistance to change. In any event, no

(1) C. Williams, Where in the World? (Epworth, 1965).

(2) The United Presbyterian Church, U.S.A. (1961), *op.cit.*, p. 23.

(3) W. Oates (1957, b), *op.cit.*, p. 7.

appreciable or significant modifications have been initiated, apart from isolated attempts to establish 'team' ministries.

In response to criticisms of the system, a special committee was commissioned by the General Assembly to undertake an extensive Survey of the Parochial System between 1944 and 1948. This committee's inquiries discovered general agreement throughout the Church that the system was appropriate in rural areas but was anachronistic and largely ineffective in large towns and urban areas.⁽¹⁾ The committee recommended seven experimental modifications for the consideration of Presbyteries⁽²⁾, but received little response or support. Significantly, in 1948 the committee reported that 45 out of 66 Presbyteries had not even replied to its proposals let alone attempted to put them into effect and the committee asked to be discharged.⁽³⁾ Five years work had been unproductive. Despite the expression of continuing discontent with the existing structure, the position has remained virtually unchanged.

This is a puzzling phenomenon and the reasons for it are obscure. There are undoubtedly practical and procedural difficulties involved with respect to the availability, status, stipends, and direction of ministers, but it would seem that these difficulties are not insurmountable if the need for re-formation is accepted. One is forced to consider whether there may not be more potent forces behind the Church's inflexibility and resistance to change at this point. It is interesting to note that a major practical obstacle to the adoption of new patterns

(1) See "Survey of the Parochial System", Reports to the G.A., 1944-1948.

(2) Reports to the G.A., 1946, p. 637 f.; 1947, p. 498.

(3) Reports to the G.A., 1948, p. 172.

of ministry has been the "status" of ministers.⁽¹⁾ Despite their avowed dissatisfaction, one wonders whether ministers are free to surrender a measure of their status, security, and autonomy within the parish system in order to seek new patterns and structures for the mission of the Church. The analogy of blackbirds and their 'territories' immediately springs to mind. The possibility that adherence to a traditional structure, which is recognized as being inappropriate, is in fact a subtle security-operation in a changing physical and social environment is inescapable. Such a self-preserving security-operation, of course, need not be one-sided. It may be that the system is also sustained by parishioners' dependence on a familiar local institution to which they are committed in terms of finance, real estate, and emotional attachment. Being based on a Presbyterian form of Church government, major changes in the Church of Scotland can only occur through a lengthy democratic procedure and depend upon the consensual agreement of clergy and laity.

In the meantime, Church of Scotland ministers are responsible for exercising their ministry within specific parochial territories. This is the field of their life and work. With respect to health, one wonders to what extent and what ways the health experience of individual ministers is affected by their immediate parish environment. Furthermore, the anomalies and fragility of the parish system in the conditions of socio-cultural change introduces the issue of the healthiness of attempting to sustain a traditional structure devised for a rural

(1) See Reports to the G.A., 1944, p. 520; 1947, p. 519; 1950, p. 755; 1953, p. 93; 1965, p. 77, 681 f.; 1968, 187 f.; 1969, p. 720-21. Ministerial 'status' has become something of a 'hardy annual' and is currently under the review of several committees in an attempt to formulate regulations governing a minister's status in "team ministries".

culture in the context of an urban-industrialized society.

2. Occupational Mobility

Another distinctive feature of the parish ministry which emerges from the experience of these ministers is the relatively high rate of occupational and geographical mobility which occurs in the parochial system (see Table 2). Minister B has been the most mobile of this group, having occupied five parishes in a career of more than thirty years. These parishes have been widely dispersed, each with its own distinctive geographical, climatic, and socio-cultural characteristics. This means that he has had to re-establish his home and family life and has had to develop a new pattern of interpersonal and social relationships every six and a half years on average. The experience of the other three is similar and is consistent with the general pattern of occupational mobility in the Church of Scotland ministry.

The average period in each parish is seven and a half years and at this rate the average minister would expect to occupy five parishes in a ministry over forty years. These figures are minimal because they are only based on movements subsequent to ordination. In addition, taking these four cases as examples, each had a period as a probationer assistant, one (Minister A) had experience as a Chaplain to the Forces, and two were engaged in active war-time service prior to ordination.

The mobility of Church of Scotland parish ministers is also evident in the number of interparochial "translations" or transfers each year (see Table 4: over). The number of translations varies annually, but between 1946 and 1962 it was in excess of 85 and often more than 100 each year. This represents an annual rate of 3-5% of the total parish manpower without taking into account the frequent movements between the parish ministry and non-parochial ministries or from secular employment

TABLE 4. MINISTERIAL RESOURCES - BASIC STATISTICS, 1930-1969.

YEAR	CHARGES	COMMUNICANTS	PARISH MINISTERS	ORD/ADM.	TRANS.	RET/RES	DEC'D.
1930	2,892	1,271,095	(C.2,790)	67	131	72	85
1931	2,720	1,280,620	.	81	140	78	102
1932	2,679	1,287,432	.	89	99	83	91
1933	2,652	1,289,145	.	99	76	64	95
1934	2,615	1,290,271	(C.2,510)	94	77	64	86
1935	2,602	1,288,648	(C.2,500)	100	88	56	78
1936	2,588	1,288,571	.	71	77	43	97
1937	2,565	1,284,450	.	104	89	61	86
1938	2,536	1,286,509	.	98	85	58	73
1939	2,538	1,285,011	2,409	103	63	56	88
1940	2,507	1,278,297	.	86	70	49	102
1941	2,483	1,268,839	.	66	52	56	87
1942	2,466	1,261,890	.	70	79	58	83
1943	2,454	1,262,678	.	74	64	62	97
1944	2,443	1,264,125	.	55	72	66	81
1945	2,426	1,259,927	2,265	78	84	97	84
1946	2,410	1,261,646	2,246	114	107	114	92
1947	2,387	1,257,167	2,242	101	110	94	88
1948	2,377	1,263,423	2,218	96	134	94	71
1949	2,357	1,268,315	2,193	96	113	74	81
1950	2,348	1,268,315	2,206	97	118	80	86
1951	2,340	1,273,027	2,210	101	88	97	88
1952	2,322	1,278,468	2,162	74	89	74	82
1953	2,303	1,283,305	2,149	67	89	89	80
1954	2,296	1,292,127	2,160	64	100	95	79
1955	2,289	1,307,573	2,113	62	109	90	66
1956	2,280	1,319,574	2,080	61	110	59	79
1957	2,272	1,315,630	2,042	72	103	67	78
1958	2,257	1,315,466	1,982	64	106	82	77
1959	2,242	1,306,661	1,942	62	109	77	57

YEAR	CHARGES	COMMUNICANTS	PWISH MINISTERS	ORD./ ADM.	TRANS.	RET./ RES.	DEC'D.
1960	2,134	1,308,816	1,959	66	104	63	52
1961	2,093	1,292,617	1,928	69	94	59	73
1962	2,069	1,281,559	1,927	64	86	59	77
1963	2,031	1,268,887	1,890	63	65	62	63
1964	2,027	1,259,162	1,888	60	71	52	61
1965	2,016	1,247,972	1,835	68	60	71	57
1966	1,994	1,233,808	1,859	57	93	63	61
1967	1,969	1,220,023	1,814	57	103	72	61
1968	1,927	1,201,833	1,827	77	89	65	57
1969	1,919	1,178,334	1,789	67	79	63	50

TABLE 5. DECENNIAL TOTALS : MINISTERS ORDAINED & ADMITTED ,
RESIGNED & RETIRED , and DECEASED , 1930-1969 .

DECENNIOUM	ORDAINED/ ADMITTED	RETIRED/ RESIGNED	DECEASED
1930 - 1939	906	635	881
1940 - 1949	836	764	866
(1946 - 1955)	(872)	(901)	(813)
1950 - 1959	724	812	772
1960 - 1969	652	629	662
TOTAL	3,118	2,840	3,181

* Abbreviations :

ORD./ADM. - ORDAINED AND ADMITTED

TRANS. - TRANSLATED

RET./RES. - RETIRED OR RESIGNED

DEC'D. - DECEASED

and mission posts back into the parish ministry. Such a high rate of occupational and geographical mobility is characteristic of few other occupational and professional groups.

At one time the Church of Scotland had a notable tradition of long-term ministries and it was relatively common for ministers to devote their entire career to one parish. It was also common for ministers to gain a few years experience in their first parish and to then remain in their second parish until retirement. Indeed, the advantages and benefits of a life-time ministry to one parish were explicitly put before candidates for the ministry and such ministries were actively recommended as a real test of vocation and character.⁽¹⁾ However, this tradition has evidently been lost over the last quarter century and such ministers are now rare.

With reference to health and occupational hygiene two observations can be made. In the first place, in view of such mobility and varied experience the minister's immediate parish environment appears to assume less importance as a variable. The average minister experiences a variety of environmental conditions and it would seem that he moves too frequently for any particular environment to make a lasting impression on his well-being.

On the other hand, the phenomenon of mobility as a characteristic feature of the parish ministry in general assumes greater significance as a possible health factor. This warrants closer examination. The healthiness or unhealthiness of occupational mobility and all that it entails for the individual minister must be called into question. Each move presents the minister with the problem of adjusting to a unique parish environment and involves him in the process of establishing a new 'place' in the world. It necessitates leaving a familiar 'place' and

(1) For instance, see the advice offered to candidates for the ministry by J. Oman, The Office of Ministry (S.C.M. 1928), p. 3 f.

establishing a new space, physically and socially. In particular, he has to form personal and social relationships, develop a new pattern of recreational and social activities, and establish a new home. To an extent he is fortunate in that he moves into a ready-made place within an existing community provided by his congregation, a place which assures him of status, role, and divers opportunities for interpersonal relationships. Whether he can in fact become a part of that community within a few years is questionable and will depend upon his facility for engaging in interpersonal relationships just as it will be dependent upon the quality of the existing communal relationships. No matter how favourable the conditions, the healthiness of such social discontinuity must be in question.

Moreover, in most cases, this social discontinuity does not simply affect an individual minister; it usually affects a total family unit including the minister's wife and children.⁽¹⁾ The healthiness of such mobility and the educational, occupational, and social discontinuity associated with it must also be questioned in relation to family well-being and the health of other individuals in the minister's family. Under these conditions, one wonders whether members of a minister's family are ever able to acquire a sense of belonging to a particular community or whether they can ever establish secure interpersonal relationships. Unlike the minister himself, members of his family do not have a ready-made place in the community except as "the minister's wife" or as "the son of the Manse"; and the healthiness of the hidden assumptions and expectations behind such stereotype labels is equally questionable.

(1) According to the figures established in the 1951 Scotland Census, 75.7% (2,171: 2,867) of the total population of Church of Scotland ministers were married. Of these, 87 were widowers and only 2 had been divorced. Of the unmarried men it could reasonably be expected that a proportion, especially in younger age groups, would subsequently marry.

Whatever the effects, occupational mobility and consequent social discontinuity are outstanding features of the minister's life.

3. The Manpower Crisis

Closely allied with the inequitable deployment of manpower throughout the parish system is the fact that the Church of Scotland has experienced increasing difficulty in staffing the parish system. The parish minister finds himself as one of a progressively diminishing population. It is not over-dramatic or an exaggeration to suggest that the Church of Scotland has been and still is confronted with a manpower shortage of critical proportions. In the light of the facts, a detached observer would have grounds for predicting the extinction of the 'species'. This is a state of affairs long recognized by the Church's administrators and of which the individual minister could not be ignorant.

The number of active parish ministers has decreased by approximately 1,001 between 1930 and 1969, that is an absolute reduction of 35.8% (See Table 4: q.v.). In the same period the reduction in the number of parishes (net 961) has not simply been a matter of deliberate streamlining and rationalisation; it has been imposed by necessity as the Kirk has not been able to provide adequate manpower to staff the system. There has been a progressive decline in the absolute number of men ordained and admitted to the ministry over this period: 906 were ordained and admitted in the pre-war decade, 1930-1939, and the number has fallen to 652 in the last decade, 1960-1969 (See Tables 4 and 5: q.v.).

The progressive reduction in the Church's manpower has not only been absolute, it has also been a relative reduction of similar proportions. Over this period the Scottish adult population has remained reasonably constant, showing an irregular and slight increase from 1930 to 1969. Furthermore, as fewer young men have entered the ministry and as older

groups of men have been encouraged to enter the ministry so the average age of the ministry has steadily risen and now exceeds fifty years of age. With this top-heavy age distribution a higher proportion and accelerating rate of losses through illness, retirement, and death could reasonably be expected. If the present rate of decline continued the ministerial resources of the Church of Scotland would be halved by 1980 and would be decimated by 1990.

The seriousness of the position was disclosed in a report to the General Assembly in 1948⁽¹⁾ and steps were taken to initiate more vigorous recruitment campaigns to present the claims of the ministry to young men. The introduction of a modified course of training for War-Service Candidates alleviated the situation temporarily with a large influx of candidates between 1946 and 1951. But there was a marked drop in candidates when this scheme was discontinued and recruitment has remained at a low level ever since (See Table 4: q.v.). In fact, between 1950-1959 the number of retirements and resignations (812) far exceeded ordinations and admissions (724. See Table 5: q.v.), and since 1952 the admissions have been barely sufficient to compensate for annual losses from the parish ministry.

- (1) A special report on Ministerial Manpower (Reports to the G.A., 1948, p. 527 ff.) compared the position in 1947 with that in 1939 and provided the following comparative statistics.

	1939	1947
Charges	2,538	2,387
Parish Ministers	2,419	2,242
Vacancies	119	144
Probationers	205	71
Final Year Students	100+	34

These figures speak for themselves and the General Assembly has received an annual report on ministerial resources available ever since.

The manpower crisis has been a major source of concern for the Church's administrative bodies and has received the attention of numerous General Assembly committees in the last two decades.⁽¹⁾ Almost invariably it has been presented as essentially a problem of recruitment and the reasons for the evident reluctance of young men to offer themselves for the ministry has been the subject of extended discussion and speculation.⁽²⁾ Whatever the reasons, it is quite evident that the Church has not found a solution and active recruitment campaigns have been unproductive. It reached the point, in 1958, that a General Assembly Committee recommended that men with suitable qualifications and experience in other professions should be encouraged to enter the ministry for a few years after their retirement,⁽³⁾ which is a measure of the magnitude of the problem and is perhaps indicative of the serious concern which it has provoked. It certainly appears to be an extreme solution.

This phenomenon is a significant aspect of the minister's 'world' which affects him directly and personally. The individual minister could not help but be aware of the facts. He finds himself as one of an ever-diminishing and ageing population. An inevitable consequence is that the responsibility and burden of carrying out the 'work' of the ministry in the parish system has fallen on progressively fewer men and there is no immediate prospect of this process being reversed or even retarded. The 'work-load' and area of responsibility of many parish ministers has inevitably multiplied, especially since the war, and one would expect this to take its toll in terms of personal health. One would also expect

(1) For instance, Reports to the G.A., 1950, 747 ff.; 1954, 464 ff.; 1958, p. 576; 1964, p. 514 ff.; 1965, p. 682; 1969, p. 663.

(2) In particular, the report of the Education for the Ministry Committee offered the most comprehensive examination of the possible reasons for this situation (Reports to the G.A., 1954, p. 466 ff.)

(3) Reports to the G.A., 1958, p. 576.

this development to have a negative effect on the morale and emotional well-being of individual ministers. It is not a picture which would normally inspire a sense of security or confidence in the future. It is also curious to note that every report, without exception, has considered the problem in terms of recruitment and the shortage of candidates. The manpower crisis has never been considered from the other end, as far as one can tell from the published reports, in terms of wastage from the ministry. One wonders whether losses due to illness, emotional disturbances, disability, and death may not have compounded the problem. Again, this is an aspect of the minister's 'world' which bears closer scrutiny.

4. Income and Economic Security

The parish minister is assured an income of which he cannot be deprived and which cannot be withheld, unless he happens to be 'deposed' through disciplinary procedures. Regardless of the type of parish or position which he occupies, he is at least assured a minimum stipend (£1,150 in 1969) together with a Manse. On the surface of it, this would seem to afford him a reasonable measure of economic security. By contrast with the clergy of most other denominations in Britain, indeed, it could be said that he is well-paid. As is true of the parochial system in general, however, there are marked disparities in the stipend structure of the Church of Scotland.

In 1968, when the minimum stipend was £1,080, the basic stipends of these four ministers ranged from £1,080 up to £1,700 (See Table 3: q.v.). and it is clear that their respective salaries bore no relation to their individual qualifications, experience, responsibilities, or personal needs. Minister D, for example, with the largest parish population in a demanding new housing development scheme, with the largest family and all his children still at school, with qualifications equal to those of his

colleagues, and with a little more experience than Minister C, was on the minimum stipend which any newly ordained minister would expect to receive. When asked what had been his greatest source of anxiety in the parish ministry his immediate response was "Money!" He frankly disclosed that he had accepted the position of part-time Chaplain to a large hospital, in addition to his parish duties, specifically in order to supplement his stipend and to alleviate the financial pressures to which he was subject. Minister C, by contrast, also with a young family, equivalent training and qualifications, with an average sized suburban congregation, and the least experienced of these ministers received a stipend of £1,700 which placed him in the top 5 per cent in the Church of Scotland.

Variations in the Church of Scotland stipend structure are principally contingent upon the type, locality and resources of individual congregations. Any advance on the minimum stipend is dependent upon the individual congregation's discretion and resources. (1) In consequence, Minister C's congregation, with a solid middle-class core and a sound financial organisation, is able to offer a stipend well in excess of the minimum while Minister D's congregation, chiefly comprising clerical and semi-skilled labouring occupations, is unable to provide a full stipend and has to be subsidized by the Maintenance of the Ministry Fund to attain the minimum. The system is flexible but gives well-endowed congregations and their ministers a marked

- (1) A congregation determines its terms of settlement in consultation with the Presbytery and Maintenance of the Ministry Committee. A well-endowed congregation is at liberty to offer a stipend in excess of the minimum on condition that it contributes a suitable amount to the fund in addition (Year Book, 1968, p. 31-2). For example, St. Giles' Cathedral, Edinburgh, paid a stipend of £2,000 in 1968 and contributed a further £1,350 to the fund.

advantage. The justice of this position has frequently been questioned⁽¹⁾ but with little practical effect.

It should be remembered, as is often pointed out, that a minister's appointment includes the provision of a manse.⁽²⁾ He is assured of a minimum stipend and also a home, together with the security of tenure afforded within the Presbyterian Form of Church Government. It would seem that the provision of a minimum stipend and a manse should provide the minister with adequate economic security and should enable him to maintain a suitable standard of living. However, for each of these ministers, especially Minister D, economic pressures have been a significant source of anxiety.

The benefits of having a manse provided are dubious. The expense of furnishing, lighting, heating and maintaining a sizeable, two-storey, stone dwelling with large, spacious rooms may be very considerable and may be a drain on the minister's moderate stipend. Moreover, a major concern for each of these ministers has been the anticipated difficulty of finding adequate accommodation following retirement. At that point each minister is faced with the problem of obtaining his own home and his moderate stipend allows little opportunity for saving to prepare for that eventuality. Unless he has private sources of income this may understandably be a significant source of worry. On retirement he is guaranteed an annuity from the Aged and Infirm Ministers' Fund,⁽³⁾ but it is not sufficient to meet this need.

(1) Reports to the G.A., 1943, p. 582; 1944, p. 519-20; 1946, p. 609 ff.; 1953, p. 93-4; and especially 1965, p. 77-9.

(2) Practice and Procedure, op.cit., p. 49, 272.

(3) This annuity increased from £300 in 1960 to £600 in 1969.

Three points of relevance arise from the existing stipend structure operative in the Church of Scotland. One wonders whether the obvious disparities in the stipend structure, with a variation of over £1,000 from the minimum to the highest paid, arouses any discontent, resentment, or frustration within the ministry of the Church. Should the minister of a prosperous West End church be paid so much in excess of the minister of a rural parish? Should a well-endowed, middle-class, suburban congregation have such a clear advantage over a young, labouring class, housing scheme congregation? On what basis can such differentials as exist be justified? These questions have been raised⁽¹⁾ but our chief concern is whether it has any bearing on the health and emotional well-being of ministers.

In the second place, it has been suggested that the moderate stipend offered to ministers by comparison with those offered in other professions, business, and industry may be a major reason for the critical shortage of men entering the ministry and may contribute to the growing number of 'drop-outs' entering secular employment.⁽²⁾ Given the present position, the Church is not able to compete at an economic level with those occupations which offer university graduates considerable remuneration. This may be a deterrent to young men entering the ministry and may stimulate others to leave its ranks. This is not necessarily an indictment of the individual's devotion or sincerity. After all, the welfare and security of a total family unit usually has to be considered.

Then, thirdly, one wonders what effects the economic pressures to which the average minister is subject may have on his health and

(1) Especially Reports to the G.A., 1965, p. 77-9.

(2) Reports to the G.A., 1942, p. 582; 1943, p. 448; 1954, p. 468; 1969, p. 734.

particularly on his emotional stability. Although popular opinion not infrequently assumes that the minister is "well-off, after all he has a house provided, doesn't he?", the truth of this stereotype is dubious. Admittedly the minimum stipend has increased from £400 in 1947 to £1,150 in 1969 and the retirement annuity has risen steadily from £300 in 1960 to £600 in 1969. Nevertheless, the minimum stipend has barely kept pace with the cost of living in real terms and it is questionable whether it has kept up with escalating prices and wages in recent years. In the opinion of the Maintenance of the Ministry Committee the minimum stipend has been sufficient to simply 'make ends meet', and no more.⁽¹⁾ In 1969 it was reported to the General Assembly that "In the last two years 39 ministers of our Church, whose ministries lay between those years of 1939 and 1969, died and left estates of less than £1,000".⁽²⁾ The Committee Convener observed: "These were not spendthrifts: they were douce and honest, fulfilling their ministries with much acceptance. They brought up their families and did their best for them. And that is what they had to leave!"⁽³⁾

In face of such facts and the economic pressures to which ministers may well be exposed one is forced to consider the possible effects in terms of occupational hygiene and personal health. When this issue is raised it is invariably answered in terms of the sacrifice and self-denial which is expected of the minister, not simply as a matter of necessity but as an intrinsic characteristic

(1) Life and Work, Sept. 1969, p. 9.

(2) Ibid.

(3) Ibid.

of the ministry.⁽¹⁾ The ministry in its very nature requires personal self-sacrifice, austerity in attitudes and habits, emotional restraint, stringency in material things, and moderation in pleasures. In this regard, for example, it has been said of the ministry:

"It is to special honour that they are called, and the special dignity implies special sacrifices and special readiness, and even eagerness to make and welcome opportunities of self-sacrifice.He must stand on a higher level of spiritual vitality and favour than ordinary men."⁽²⁾

This ideal, embracing the ideal of self-sacrifice, is an important component of the Presbyterian ethos and is frequently reiterated in manuals on the ministers life and work.⁽³⁾ Self-sacrifice of this kind is expected not only of the minister himself but also of his wife and family. It has been suggested that, for this reason, it is all the more important that the minister's wife should be a "devout Christian" so that she is prepared to share the inevitable sacrifices.⁽⁴⁾ In this view the minister's vocation, and the material sacrifice and austerity it involves, devolves upon his wife and family whether or not they share his sense of a special vocation.

(1) For example see Reports to the G.A., 1954, p. 468. Also see J.O. Dykes, The Christian Minister and His Duties (T. & T. Clark, 1908), p. 56, 73, and K. Kennedy, The Minister's Vocation (The St. Andrew Press, 1963), p. 131-2.

(2) J.C. Wilson, Ministerial Life and Work (Oliphant, Anderson & Ferries, 1901), p. 50.

(3) This theme and the influence of Puritanism on the Scottish ministry will be taken up in Chapter 7 in considering the minister's personal life.

(4) J.O. Dykes (1908), op.cit., p. 73.

However, the fundamental question is whether the Church of Scotland minister enjoys adequate economic and material security and whether this aspect of their world has any relevance for their experience of health and illness.

5. THE CHURCH AND SOCIETY

A Church of Scotland minister, as a representative of a national institution, is responsible for a parish and not simply for the care of a local Christian community or congregation. In this respect their experience is comparable with that of their Episcopal colleagues in the Church of England and is a dimension of their experience which will be unfamiliar to those of other branches of the Presbyterian and Reformed tradition. The Church of Scotland is the only Presbyterian Church with such national status and almost certainly no issue has been more divisive or a greater source of contention within this Church. Each of these ministers is acutely aware of his parochial as distinct from congregational responsibilities and each accepts and feels responsible for every resident in his territory regardless of religious convictions or affiliations. Two central questions arose with reference to this facet of their world.

In the first instance, the question arises as to the nature of the minister's role in the context of the local parish. What is the nature and extent of his parochial responsibility? The Church's national responsibility has a direct influence on the pattern of the individual's ministry but his role and functions in this realm are ill-defined. The Church of Scotland's first responsibility is "to maintain religious ordinances throughout the land, and to provide Ministry of Word and Sacraments to all our people by means of a territorial ministry"⁽¹⁾ and the parish minister is responsible for

(1) The Church of Scotland Year Book, 1968, p. 31.

evangelism and pastoral care within a total parish. The principle is clear but its practical application is far from certain.

The quality and extent of the relationship between the Church and society varies appreciably from parish to parish, as is illustrated by comparative figures from these four parishes.

Parish	Communicant Members	Percentage Active	Percentage Parish Population
A (Rural Linked)	372	20%	60%
B (Country Town)	1,220	25%	50%
C (Suburban)	1,020	25%	40%
D (New Housing)	726	30%	10%

These figures, which are only approximate estimates, suggest that the Church of Scotland as a proportion of the local parish population tends to vary in inverse proportion to the size and density of the local population. The Church is most representative in sparsely populated areas, as in the case of Parish A where the minister's congregation is virtually his parish. It is least representative in more recent, dense areas of population, as in the case of Parish D where the minister is responsible for a large unchurched population. In the case of Parish C the congregation as a proportion of the local population is grossly inflated in view of the fact that the bulk of the congregation are drawn from beyond the parish bounds. It also appears, however, that the active membership of local congregations tends to be in inverse proportion to the congregation's representativeness. At one extreme, Minister A's congregation is closely identified with the local community but is largely inactive and, at the other extreme, Minister D's congregation represents a small proportion of the local population but is significantly more enthusiastic. The

contrast is striking and both have their problems: Minister A with the problem of activating a largely non-participant congregation and Minister D with that of making contact with and meeting the needs of a considerable unchurched population. In either case the potential tension between congregational and parochial responsibilities is apparent.

Beyond these particular examples, there is irrefutable evidence that the Church of Scotland's representativeness of the Scottish population is rapidly declining. The communicant membership of the Church of Scotland has been dramatically reduced since 1956 (See Table 6 and Figure 3 following). Following a war-time slump, there was a steady recovery in membership up to 1956 when it reached a peak of 1,319,574 communicant members. Within fourteen years it fell by 141,240 in absolute numbers which represents an absolute loss marginally in excess of 10 per cent and for the average congregation is a loss of approximately 66 members. This loss has also been relative to the total population. Church of Scotland membership at the turn of the century represented 46 per cent of the adult population over twenty years of age (Table 6 and Figure 3). By 1947 the proportion had fallen to 36 per cent. Despite the dramatic decline in absolute numbers since 1956 the relative proportion of the adult population remained steady at 36 - 37 per cent up until four years ago. In this period, 1966 - 1969, membership decreased absolutely by 69,638 and relatively until it now represents 34 per cent of the Scottish adult population, that is, a relative decline of 12 per cent since the turn of the century.⁽¹⁾

(1) The Church's membership as a proportion of the adult population over 20 years would be somewhat lower, if allowance could be made for the proportion of members under 20 years.

TABLE 6. CHURCH OF SCOTLAND MEMBERSHIP: COMPARATIVE DATA .

YEAR	COMMUNICANT MEMBERS	ANNUAL ATTENDANCE	SCOTTISH POPULATION OVER 20 YEARS	% ADULT POPN	TOTAL ADMISSION OF NEW MEMBERS
1901	1,163,594	73.0	2,520,946	46.1%	110,098
1911	1,219,587	75.5	2,761,530	44.1	100,561
1921	1,277,634	69.4	2,964,685	43.09	106,703
1930	1,271,095	—	3,022,100	42.05	92,267
1931	1,280,620	72.4	3,092,814	41.3	94,570
1935	1,288,648	71.7	3,258,600	39.8	79,107
1936	1,288,571	71.5	3,274,600	39.3	79,897
1940	1,278,297	66.1	3,360,000	38.04	69,739
1941	1,268,839	60.2	3,325,000	38.1	57,942
1945	1,259,927	58.9	3,027,000	41.6	59,467
1950	1,268,315	67.8	3,488,000	36.3	84,534
1951	1,273,027	68.3	3,490,900	36.4	84,909
1955	1,307,573	69.5	3,453,000	37.4	98,399
1956	1,319,574	69.5	3,495,100	37.7	94,626
1960	1,308,816	74.0	3,502,100	37.3	79,913
1961	1,292,617	71.3	..	36.9	78,497
1965	1,247,972	71.0	3,439,500	36.2	74,802
1969	1,178,334	68.5	3,445,300	34.2	62,045

(Note : Annual Attendance - the proportion of members who communicated at least once during the year . Also , the % of the adult population is inflated because it is not possible to calculate the number of Kirk members under 20 years of age.)

FIGURE 3. CHURCH OF SCOTLAND MEMBERSHIP, 1901 - 1969.

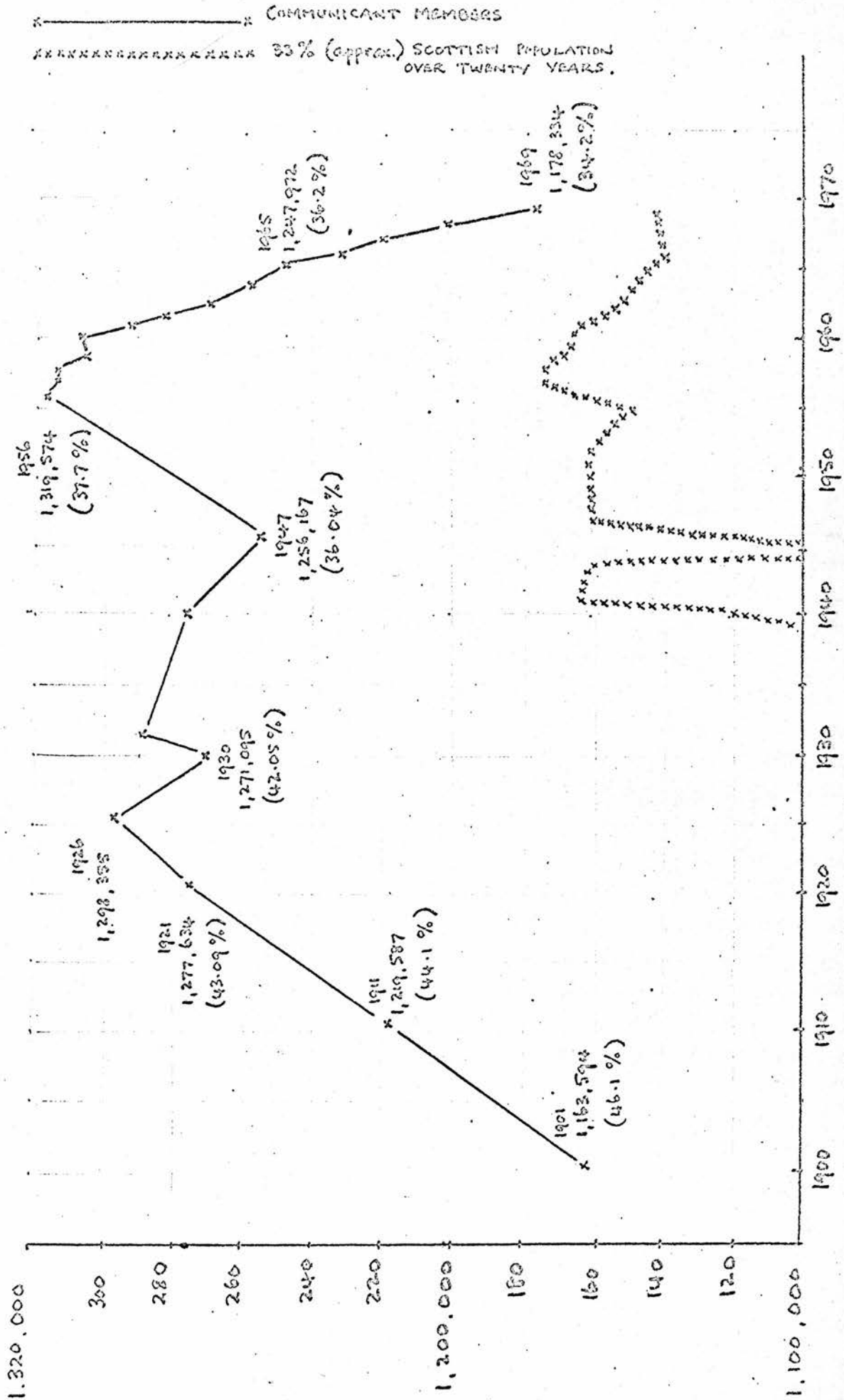
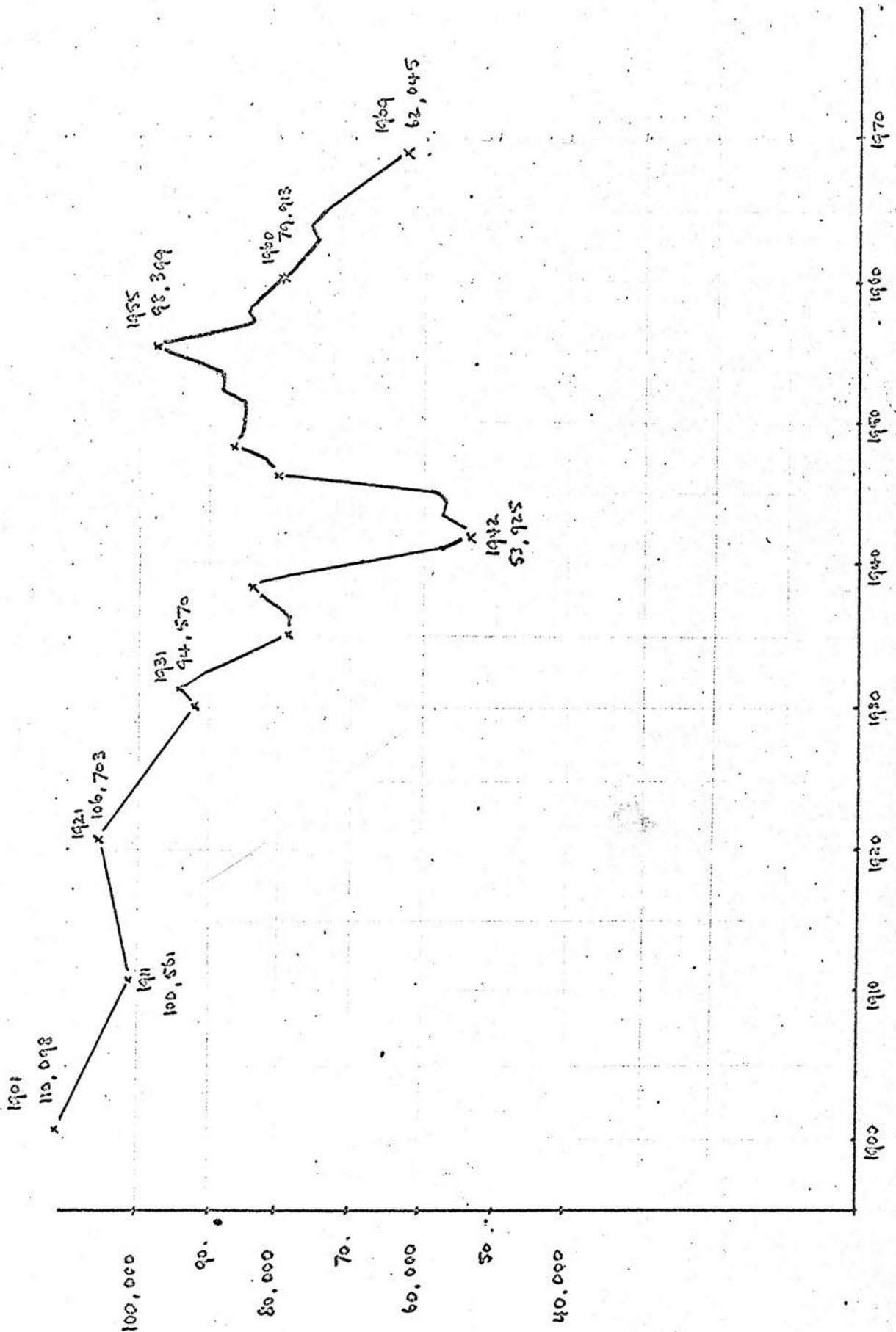


FIGURE 4 . . . ANNUAL ADMISSION OF NEW MEMBERS TO THE CHURCH
OF SCOTLAND , 1901 - 1969 .



The phenomenon of dwindling Church membership indicated by these figures cannot be attributed solely to more efficient record-keeping or to vigorous purging of the rolls, although both may have had some effect. Fluctuations in the membership of the Church of Scotland have been paralleled by equivalent variations in the intake of new members (Table 6 and Figure 4). Since 1955 the annual admission of new members has fallen by 36,354 per annum. In consequence, the total membership of the Church of Scotland is now lower, absolutely and relatively, than it has been at any time since 1901..

It is impossible to escape the conclusion that the Church of Scotland has been progressively losing contact with and its significance for the Scottish population. Although it retains its status as a national institution, the Kirk has certainly become less representative of the population in general. The gap between the Church and society has evidently increased significantly since 1955-6: candidates for the ministry, the proportion of candidates proceeding to ordination, the numbers dropping out of the active ministry, the annual admission of communicant members, and the absolute and relative membership of the Kirk have all decreased appreciably in that time. It is unlikely that a parish minister could remain ignorant of these developments and it is not a picture which would normally instil a sense of security or satisfaction.

In view of these developments, one wonders whether they have had any effect on the morale and sense of fulfilling a worthwhile function of Church of Scotland ministers. Moreover, in view of the Church's national responsibilities, the individual minister is faced with the question as to whether his primary responsibility is to his parish or congregation, as to whether his mission is to the unchurched parish

in the first instance or whether his central role is to equip his congregation for their ministry to the parish. Apart from the potential effects of the decline in institutional religion which these figures reveal, the possible tension between parochial and congregational obligations may be of relevance for the health of Church of Scotland ministers.⁽¹⁾

Beyond the parochial sphere, the implications of the Kirk's national character for the parish minister are not so readily defined or described. Together with Scottish Law and Judiciary, the Kirk was established and protected as an essential component of the Scottish national structure by the Act of Union in 1707. In addition, therefore, to its peculiar religious function the Church of Scotland has assumed responsibility for fulfilling a cultural and, in some measure, a quasi-political role in the national realm. It would seem that, as a representative of a national institution, the parish minister is put in the position of fulfilling more than a religious function and of adopting a role which has politico-cultural aspects.

The General Assembly, as representative of at least one third of the adult population, has been described as the only equivalent of a Scottish parliament, as a forum for the expression of national sentiments, and as "the voice of Scotland" and this role has been willingly and actively accepted by the Assembly.⁽²⁾ "The history, the tradition, the sentiment, the literature, and the national consciousness of the Scottish people", it has been claimed, have been

(1) The question of a minister's role and functions within the Church of Scotland will be considered in Chapter 6, following.

(2) J. Hight, The Churches in Scotland Today (Jackson, 1950), p. 8. Also see Life and Work, July, 1958, p. 157: "Scotland in Assembly: Our Only National Forum".

bound up and expressed in the worship, government, and life of the Church of Scotland.⁽¹⁾ It has been claimed, furthermore, that the Church of Scotland has done more than any other institution to make Scotland what it is and that the Kirk therefore has a peculiar responsibility in the cultural, social, ethical and political areas of national life.⁽²⁾ In fulfilling this curious politico-cultural role, the General Assembly has accepted an obligation for protecting and preserving "the Scottish way of life" and "Scottish culture".⁽³⁾ The Kirk, in view of its national status, has "a right and a duty to stir the public conscience generally for the sake of the Christian good of Scotland"⁽⁴⁾ and, to this end, the Assembly generally opposes any supposed threats to established cultural traditions, social patterns, and moral standards.

It has become increasingly difficult to maintain this exalted, if not pretentious and chauvinistic, role against the flow of socio-cultural change and as the Kirk has become less representative of the Scottish population so too it has exercised diminishing influence on national events and decisions. It is questionable from a theological point of view whether it is the purpose or prerogative of any branch of the Church to accept the role of a national super-ego or to act as a guardian of a specific culture. The relationship between the role of cultural conservation and the mission of the Church as "the body

(1) Reports to the G.A., 1947 (Inter Church Relations Committee).

(2) Reports to the G.A., 1948, p. 155 (National Church Extension Committee) and also Reports to the G.A., 1948 (Church and Nation Committee).

(3) Reports to the G.A., 1958, p. 439-40 (Church and Nation Committee).

(4) Reports to the G.A., 1964, p. 341 (Social and Moral Welfare Committee).

of Christ" is not clear. But that is a matter of considerable dispute. The fact is that the General Assembly of the Church of Scotland has evidently accepted such a role, although not without recognition of the dangers involved.⁽¹⁾ In maintaining the status quo and in protecting the traditions of a particular culture there is always the danger of the Church becoming so closely identified with a specific socio-cultural pattern that it is rendered incapable of adjusting to changing conditions or of fulfilling its peculiar mission. In such circumstances the Church may be little more than a cultural phenomenon, a public institution.

The question at issue is whether the Church's national role is to maintain the status quo and established traditions or whether it is to foster and encourage radical innovation or whether the Church should apply its own terms of reference which set it free from slavish adherence to either extreme.⁽²⁾ In some of the recent deliberations of the General Assembly concerning political and ethical topics there has been evidence of cleavage in the ranks of the clergy and laity along these lines. A split between traditional, radical, and moderate attitudes has been apparent, for instance, in Assembly debates and votes on the provocative issues of the Homosexual Practices Act in 1967 and 1968⁽³⁾ and in 1970 on the prescription of contraceptives

- (1) Reports to the G.A., 1967, p. 501 ff. (Social and Moral Welfare Committee).
- (2) The merits and dangers of these positions are discussed by the Social and Moral Welfare Committee in Reports to the G.A., 1967, p. 501 ff. The Committee argued that the Church's role is neither to maintain the status quo nor to be swept along by radical innovations. The Church should be free of both temptations and should be free to apply its own terms of reference.
- (3) Reports to the G.A., 1967 and 1968 (Social and Moral Welfare Committee Reports). It is interesting to note that the Assembly consistently opposed the recommendations of the Wolfenden Report (1958) on homosexuality even when these had been carried into effect in civil law. However, the continuing discussion led

to promiscuous unmarried girls.⁽¹⁾ Both discussions resulted in close votes narrowly favouring a liberal position but the cleavage has been clear. These examples are only symptomatic of a more general division over the Church's role in society and responsibility to the nation.

This issue affects the individual parish minister in so far as he is an official representative of the Church as a national institution. He cannot help but be aware of the traditional relationship between Church and State, a tradition to which he belongs. At the same time he is confronted with the facts of socio-cultural change, not in the abstract but in concrete and living realities within his parish. What is his role and what are his functions under these conditions?

CONCLUSION

It seems that the peripheral structures of the Church of Scotland minister's world are in a fluid and possibly unstable state. The external characteristics of his world are visibly changing around him, as is the socio-cultural environment in which he exists. In these circumstances, with an evident decline in the influence of institutional religion and with the disruption of traditional beliefs and established social patterns and standards, almost every aspect of the Church of Scotland ministry has been subject to critical reappraisal. This has been most evident in the post-war era. The basic structures have

up to a close negative vote in 1967 which was then narrowly reversed in support of the Homosexual Practices Act in 1968.

- (1) Reports to the G.A., 1970 (Social and Moral Welfare Committee). In the interval this issue has become a matter of public dispute and at least one minister has resigned in protest against the Assembly's decision.

been maintained, but not without the expression of significant doubts and discontents within the Kirk itself.

The parochial system, which has been the norm of the Church's life for a thousand years and which has provided a basic structure of the minister's world, has been the subject of criticism. The anomalies and inadequacies of the parish, especially in the conditions of pluralistic-urban-industrialized communities, have long been acknowledged and its efficacy in the context of urban societies has been in doubt for more than a quarter of a century. New patterns of ministry have been considered and discussed but to no effect. Nevertheless, the parish system in its essentials is being perpetuated and is exactly as it was at the end of the 17th Century. In the meantime, parish ministers are in the position of having to sustain a structure which many of them consider ineffective and anachronistic.

Within this system, parish ministers experience a high rate of occupational and geographical mobility. In a total career over a period of forty years the average minister has experience of four or five parochial environments and in this process there is little opportunity to establish permanent interpersonal relationships. Social discontinuity is a fact of his life, an experience inevitably shared by his family. There is evidence that these ministers have become more mobile in the period since the last war and long-term ministries are the exception rather than the rule. The reasons for this development are not apparent but it does introduce significant questions with respect to their health.

The parish minister also finds himself as one of an ever-diminishing occupational population. There have been progressively

fewer men available to share responsibility for the Kirk's overall ministry. Following a post-war influx of war-service candidates, fewer young men have been offering themselves for the ministry, fewer of those who undergo training for the ministry proceed to ordination, more men have been resigning from the active ministry, the number of "unattached" ministers has grown, and the average age of the ministry has steadily risen leading to proportionately higher losses due to retirement and death. This is clearly not an encouraging state of affairs and the manpower crisis has received considerable attention from the Kirk's administrative bodies.

The provisions for the maintenance of the ministry assure the parish minister of what appears to be a reasonable measure of economic and material security. He has security of tenure and is guaranteed the provision of a minimum stipend, certain listed expenses, a manse, and an annuity following retirement. There are special provisions to meet the needs of disabled ministers and to assist ministers' widows and families if the need arises. However, there are gross disparities in the stipend structure of the Church of Scotland, which may well give rise to rivalry and resentment in some circumstances. Moreover, against ever-increasing prices, the Maintenance of the Ministry Committee has had difficulty in maintaining and improving the existing provisions and it is generally considered that they have just kept pace with the cost of living and enable the average minister "to make ends meet" and no more. There is reason to suspect that economic insecurity may be a prominent source of tension and anxiety for some ministers.

Unlike his Presbyterian colleagues elsewhere, the Church of Scotland parish ministers represent a national institution which accepts responsibility, in some sense, for the welfare of the Scottish society

and nation. There exists, in principle, a close relationship between the Church and society, parochially and nationally. However, there are unmistakable symptoms of the declining influence of institutional religion in Scotland. The Kirk's manpower crisis may well be a symptom of this decline. Moreover, the Kirk can claim to be representative of a progressively diminishing proportion of the Scottish population with an absolute and relative decline in communicant membership and with a significant reduction in the annual admission of new members. Each of these developments has been most apparent in the period since 1955-56 and membership is now lower than at any time since 1901. In this context, the Kirk's rightful role as a national institution has been called into question. There is a clear cleavage between those who adopt the view that the Church's responsibility is to firmly maintain established traditions and standards, on one hand, and those who contend that the Church must be prepared to welcome and encourage change and to adjust to changing socio-cultural conditions where appropriate, on the other. This cleavage has been most apparent in debates conducted at a General Assembly level on moral and political issues in recent years. The problems associated with this vexed issue of the relationship between Church and State has implications for the minister's role in the parochial realm which must be taken up in the following chapter.

It is against this background of transition and in an atmosphere of some uncertainty that the Church of Scotland parish minister fulfils his vocation and exercises his ministry. His place is to be found in the context of a parish, his particular "territory" for which he has ecclesiastical responsibility, and the parish provides a basic structure of his distinctive 'world'. But this structure is unstable and fragile and may be subject to disruption, even though the Church of Scotland

Assembly has a declared intent to maintain this particular form of 'one-man parish ministries'. Within this structure the minister, together with his family, usually leads a highly mobile life with little opportunity for securing social continuity and is afforded a measure of economic and material security which seems to be barely adequate to meet his needs. There can also be no doubt that the influence of institutional religion, as represented by the Church of Scotland, has been weakened and is still diminishing, a fact which directly affects the status, role, and functions of the parish minister.

In these circumstances, the content of the minister's 'world', in terms of role and functions, has become subject to reappraisal and attempts have been made to reformulate the minister's role. We now turn our attention to this aspect of the Church of Scotland ministers' experience.

CHAPTER 6

THE FUNCTIONAL REALM

"The contemporary Church is confused about the nature of the ministry. Neither ministers nor the schools that train them are guided by a clear-cut, generally accepted conception of the office of the ministry, though such an idea may be emerging".

H.R. Niebuhr (1956)⁽¹⁾

In describing the ministry as "the perplexed profession",⁽²⁾

H.R. Niebuhr and his co-authors trace the contemporary confusion concerning the role and functions of the minister back to the early 1930s. On one hand, they observe the existence of a kind of professional identity crisis within the Protestant ministry and uncertainty as to the fundamental role of the minister in urban societies. Then, on the other hand, stemming from this confusion, they identify a diversification of functions within the ministry. In the absence of clear-cut "master role" (Cf. S.W. Blizzard, 1958 b), it is virtually impossible to establish a set of functional priorities and conflict inevitably arises.

These contemporary phenomena of role diffusion and functional diversification within the Protestant parish ministry have been the subjects of extensive research⁽³⁾ and of numerous theoretical and practical discussions.⁽⁴⁾ But it would seem that it is still appropriate

(1) H.R. Niebuhr (1956), op.cit., p. 48.

(2) Ibid.

(3) For examples see R.J. Menges and J.E. Dittes, op.cit., under the following index headings: identity, role, role-conflict, role-expectations, role-functions.

(4) For examples see H.R. Niebuhr (1956), op.cit.; G.R. Dunstan, "The sacred ministry as a learned profession", Theology, 1967, LXX, 568; K. Kennedy (1967), op.cit.; S. Mackie, Patterns of Ministry (Collins, 1969); T.W. Manson, The Church's Ministry (Hodder & Stoughton, 1948) and Ministry and Priesthood: Christ's and Ours (Epworth, 1959);

to describe the ministry as "the perplexed profession". Of particular relevance in this context is the fact that some investigators and theorists hypothesize that there could be a significant relationship between this kind of role confusion or diffusion and the health of ministers.⁽¹⁾

At this point, we are particularly concerned with the role and functions of Church of Scotland ministers, centering attention on the experience of four parish ministers and drawing further information from other sources. Drawing on the experience of these men, an attempt will be made to describe the functional realm of the parish minister giving particular attention to those areas which may have implications for personal health.

1. THE PARISH MINISTER'S "MASTER ROLE"

The role of a Church of Scotland minister is described chiefly in theological or ideological terms, as distinct from functional or inspirational images of the ministry.⁽²⁾ He is ordained, in the first instance, "to the office of Holy Ministry",⁽³⁾ and in this office it is his primary role to be "a Minister of the Word and Sacraments" or, even more simply, to be "a Minister of the Gospel".⁽⁴⁾ Within the context of the wider ministry of the whole Christian community, his

J.K.S. Reid, The Biblical Doctrine of Ministry (Scottish Journal of Theology Occasional Papers No. 4, 1955); T. Torrance, Royal Priesthood (Oliver & Boyd, 1955); C. Williams, Where in the World? (Epworth, 1963) and What in the World? (Epworth, 1963). These are only a few examples of an extensive body of recent literature.

(1) Chapter 2, q.v.

(2) The distinction between these three conceptual orientations (ideological, functional, and inspirational) is made by S.W. Blizzard (1958 b), op.cit.

(3) Practice and Procedure in the Church of Scotland (1964), op.cit., p. 566 f.

(4) Ibid.

peculiar and distinctive ministry is as "a minister of Word and Sacraments". However, judging from Church of Scotland documents, it would seem that the nature of this role is taken as understood, for at no point is it elaborated or given more tangible substance. It is implied that his primary role is to proclaim and communicate Christian truth by various means. This is implicit in the description of a minister as a "preaching" or "teaching elder".⁽¹⁾ As traditionally understood, then, it would appear that the Church of Scotland minister's "master role" has a verbal and ideological orientation: his unique vocation is to proclaim the Gospel, both in word (preaching) and action (the Sacraments).

The ministry of Word and Sacraments is seen as the central role of the Church of Scotland parish minister and it is to this "office" that he is ordained. What does it mean in real terms, however, to be a minister of the Word and Sacraments? That seems to be taken as understood. The issue is confused, furthermore, by the fact that at his ordination the minister is committed "to bear rule in the flock" and to be "a watchful guardian of the flock", he undertakes to be "subject to the Presbytery and Superior Courts" and to take part in administering their affairs, he accepts responsibility for a specific "pastoral charge" and "the people" are placed under his "care", and he promises "to lead a godly and circumspect life".⁽²⁾ In other words, the minister's role-definition assumes administrative, pastoral, and inspirational dimensions, which are all implicit in the act of ordination; so that he is expected to be an administrator, pastor, and exemplary model of Christian faith and behaviour in addition to his preaching, teaching, and sacramental responsibilities.

(1) Practice and Procedure in the Church of Scotland (1964), op.cit., p. 110.

(2) Ibid., p. 567.

The "master role" of the Church of Scotland minister, as traditionally described, appears to be based on a number of non-explicit theological assumptions and is not so much confused as diffuse in character. One wonders whether this description of their professional identity provides individual ministers with an adequate sense of purpose or with realistically attainable objectives.

The four ministers with whom we are concerned express variant concepts of their central role. The two older men, Ministers A (Rural Linked-Parish) and B (Country Town), adhere to the centrality and primacy of the ministry of Word and Sacraments. Both stress the priority of their preaching and sacramental functions and accept the traditional role of communicating the Gospel as being normative for the ministry. Minister A places secondary importance on his administrative responsibilities, for which he has a particular flair and personal interest. Minister B, by contrast, considers that his preaching and pastoral functions are reciprocal and interdependent in fulfilling his central role and states that his basic purpose is "to lead and teach the congregation in the way of service". He therefore considers that the minister should also be an exemplary model of Christian faith and service. Although these two men express diffuse role-definitions, with proclamatory, educational, priestly, pastoral, administrative, and exemplary dimensions, they appear to be in little doubt as to the focal thrust of their ministry: it is essentially as ministers of the Word that they have a unique role to fulfil within the wider ministry of the Church.

The two younger men, Ministers C (Suburban Residential) and D (New Housing Development), seem to exemplify an attempt to redefine

the role of the ministry in the context of contemporary urban environments. Their respective role-definitions are more explicitly operational or functional in character.⁽¹⁾ Both acknowledge the unique ministry of Word and Sacraments as a necessary component of their role. But, by contrast with their senior colleagues, this does not constitute the central or primary locus of their role. Instead, the primary purpose or "master role" of the minister in their view is to teach, prepare, equip, and guide Church members, as an integrated community, to fulfil their ministry to the wider community. In other words, instead of fulfilling an essentially evangelical role the concept which they propose is distinctly more operational and is firmly located within the context of the Christian community and its ministry. This suggests a significant change in emphasis.

Minister C, for instance, considers that the pastoral role is primary and that his essential function is "to help to build and establish a pastoral community", which is an effective instrument of witness and service, and to be a pastor and leader to the leaders of that community. Similarly, Minister D expresses the view that a minister is "essentially someone who brings forth the gifts of others. Although he is a representative Christian, in some way, he doesn't do everything. If he is successful he eliminates his own job by equipping the congregation to exercise their ministry". Both have basically the same objective in mind and although evangelical, priestly, and representative dimensions are present they are reduced to secondary

(1) Some authors use "instrumental" as a synonym. Operational or functional are preferred in this context, to avoid confusion with the "empty vessel" concept of instrumentalism according to which the minister appears, by implication, to be passive, devoid of personality, neutralized, self-eliminating in order to be used by God. Cf. R.C. Johnson in *The United Presbyterian Church in the U.S.A.* (1961), op.cit., p. 48.

importance in this conceptualization of their role, which has implications for the whole shape of the ministry. For example, the minister's preaching function takes on a didactic character rather than being essentially evangelical; as the leader of the Christian community he is entrusted with responsibility for the community's sacramental and worshipping life; and the ordained ministry has a specifically congregational rather than parochial locus.

The view of these two younger men seems to indicate the possible emergence of a more functional concept of the parish ministry, as distinct from the traditional evangelical model. It is interesting to note that, by contrast with their senior colleagues, both have been trained and ordained since the last World War. The concept to which they subscribe is not unlike the role of "Pastoral Director" proposed by H.R. Niebuhr and his co-authors,⁽¹⁾ according to which the minister's functions primarily centre on teaching, pastoral care, leadership, and administration in the context of a particular Christian community. This view represents a major shift in the theological, conceptual, and practical orientation of the parish ministry in the post-war era, which has been summed-up by Hans Rudi Weber:

"The laity are not the helpers of the clergy so that the clergy can do their job, but the clergy are the helpers of the whole people of God, so that the laity can be the Church."⁽²⁾

This statement reflects the fundamental change of emphasis onto the ministry of the laity which has been occurring throughout the last quarter century.

(1) H.R. Niebuhr (1956), *op.cit.*, p. 79 ff.

(2) Quoted by C. Williams (1963 a), *op.cit.*, p. 88.

The more explicitly functional and operational concept of the ministry implicit in these views has not gained official recognition or acceptance in the Church of Scotland. Many attempts have been made to reformulate the concept of the ministry and new patterns have been considered, but such discussions invariably return to the same point: to reaffirm the primacy of the ministry of Word and Sacraments,⁽¹⁾ with an ideological and verbal basis. For example, in a review of basic principles, the Education for the Ministry Committee in 1964 asserted:

"The minister's task is, with all gentleness and firmness, to call his people to their full stature in Christ. But it is precisely as a Minister of the Word and Sacraments and not as an omniscient technician, that the Minister will accomplish what is most urgently required today";⁽²⁾

and further:

"It is as a man of the Word, by calling, gifts, and education, that he has his peculiar place and contribution".⁽³⁾

The fundamental role of the minister, as traditionally understood, is "to labour in the ministry of the Word and to preach sound doctrine diligently, plainly, faithfully, wisely, zealously, and sincerely".⁽⁴⁾ Methods of communication may change, but the content remains unchanged and the aim is always "the exposition of Christian truth".⁽⁵⁾ As recently as 1969 it has been reaffirmed that the ministry of Word and

(1) Reports to the General Assembly, 1942, p. 578; 1943, p. 452; 1953, p. 380 ff.; 1954, p. 471; 1964, p. 516 ff.; 1969, p. 717 ff.

(2) Reports to the General Assembly, 1964, p. 516.

(3) Ibid., p. 517.

(4) Reports to the General Assembly, 1943, p. 452. Cf. The Shorter Catechism.

(5) Ibid., p. 453.

Sacraments does not change in its essential nature.⁽¹⁾

However, judging from the views of the two younger ministers, the theological validity, contemporary relevance, and practical efficacy of this traditional role has been called into question by at least some of the Kirk's ministers. The issue has also received some public exposure.⁽²⁾ It is open to further investigation, however, to determine whether a significant number of men depart from the traditional role of the minister as it is understood in the Church of Scotland.

Three general observations are pertinent. First, the traditional and distinctive role of the minister in the Church of Scotland is as a minister of the Word and Sacraments. It is reasonable to assume that this role, with its ideological and verbal orientation, is normative for the majority of the Kirk's ministers. Over against this a new concept of the ministry appears to be emerging which is distinctly more functional and operational in nature and which has affinities with the concept of a "Pastoral Director". However, this contemporary concept has not gained official acceptance and further research would be necessary to determine the extent to which it affects or influences individual ministers.

Second, traditional ordination vows and prayers imply that the minister's role also has administrative, pastoral, and exemplary dimensions. These ancillary or supplementary dimensions tend to confuse the essential role of the minister and to diffuse the focal

(1) Reports to the General Assembly, 1969, p. 718.

(2) Apart from the General Assembly reports and debates mentioned, also see for example: "We need a new kind of Minister", Life and Work, Jan. 1957; "Man in the Pulpit", Life and Work, Sept. 1964; "The Sheltered Minister", Life and Work, August, 1965.

thrust of the ministry. One wonders whether it is possible, under these circumstances, for a minister to have a clear sense of purpose and a realistic set of goals. He is inevitably faced with the problem of deciding what is in fact essential to his ministry per se: is he essentially an evangelist, teacher, priest, pastor, or administrator?

Third, little mention has been made of the representative and exemplary aspects of the ministry⁽¹⁾ as they apply to the role of the Church of Scotland minister. But that does not mean that they are insignificant aspects of the minister's role and professional identity in the Church of Scotland ministry. At his ordination, the minister vows "to lead a godly and circumspect life"⁽²⁾ and a prayer is offered that his "walk and conversation may be as becomes his office".⁽³⁾ It is implied, by innuendo, that he is expected to be a representative of Christian faith and service and a model of spiritual and moral excellence. None of these men described their role in these terms; so that, at a conscious level, an "inspirational role" is secondary in their personal understanding of the ministry. However, it is likely that the representative and exemplary images of the ministry have a more subtle and powerful influence in the Church of Scotland than is immediately apparent. This issue will receive closer attention in the following chapter, when considering the personal realm of the minister's life.

2. FUNCTIONAL MULTIPLICITY AND DIVERSIFICATION

Superficially it would seem that the Church of Scotland minister has a consistent and coherent vocational role to fulfil: he is,

- (1) This subject is taken up by S.W. Blizzard (1956 b), op.cit. Also published in the United Presbyterian Church in the U.S.A. (1961), op.cit., p. 30 ff.
- (2) Practice and Procedure (1964), op.cit., p. 567.
- (3) See Ordinal and Service Book for use in Courts of the Church. (Also see The Book of Common Order (1955), p. 191)

primarily, a minister of the Word and Sacraments. When this role is translated into functional terms, however, any role-confusion or diffusion seems to be multiplied. One of the most striking features to emerge from these four cases is the functional multiplicity, diversity, and complexity of the minister's role. They provide perfect examples of what has been facetiously called "the maceration of the minister" or the chopping-up of the minister into small pieces.⁽¹⁾

An ordained minister of the Church of Scotland is required to fulfil five basic functions as minimum obligations of his ministry: the ministry of the Word, conduct of worship, celebration of the Sacraments, instruction of the young, and preparation of new communicants.⁽²⁾ The functions, embracing the functions of preacher, priest, and teacher, are consistent with the image of the Church of Scotland parish minister as essentially a man of ideas and words, whose primary responsibility is the proclamation and communication of the Word. This image is implicit in and sustained by procedures for the selection and education of candidates for the Church of Scotland ministry. Selection is based on a candidate's motives, character, and on his academic background, and stringent educational requirements have to be satisfied.⁽³⁾ Theological education has a strong ideological and verbal emphasis,⁽⁴⁾ and is designed to equip a candidate with a sound Biblical, doctrinal, and ideological foundation and to develop his verbal abilities and skills in communication.⁽⁵⁾ The fundamental assumption is that he is to be a minister of the Word.

(1) J. Sittler in *The United Presbyterian Church in the U.S.A.* (1961), op.cit., p. 79 ff.

(2) Practice and Procedure (1964), op.cit., p. 50.

(3) Ibid., p. 202-3.

(4) Ibid., p. 205-8.

(5) The basic principles and structure for the education of candidates were established in the Basis and Form of Union, 1929,

These functions, however, do not limit or circumscribe the sphere of his ministerial activities. They are simply minimum requirements. In addition, his role and status in the Church requires that he should fulfil pastoral, administrative, and organisational functions, in the congregational, parochial, and ecclesiastical spheres. He is, therefore, obliged to undertake divers functions and duties which are not directly related to his central role as a minister of the Word.

In these four cases, each minister provided a statement of his functional responsibilities and of the activities involved (a synopsis of the statements is provided in Table 7, over). When requested, three of them (Ministers B, C, and D) also provided a detailed work record for one month and the work-records for one week are presented in Tables 8, 9, and 10, following.⁽¹⁾ The extent of functional multiplicity and diversification of the Church of Scotland parish ministry is immediately apparent from these records.

and reaffirmed the priority of the four traditional subjects: (i) Old Testament Language, Literature, and Religion; (ii) New Testament Language, Literature and Theology; (iii) Church History, especially that of the early Church, The Reformation, and of Scotland; and (iv) Systematic Theology, including Apologetics, Dogmatics, and principles of Christian Ethics. In addition, candidates were to receive education in Practical Theology, comprising Homiletics, Public Worship, Pastoral Duties, Church Music, Government and Discipline of the Church, principles and methods of Christian Education, Christian methods, and Practical Application of Christian Principles. This group of "practical" subjects was to be considered from a theological and verbal point of view rather than from a technical and pragmatic perspective, as education rather than as training (Cf. Reports to the General Assembly, 1964, p. 518-521).

- (1) Minister A was not willing to provide a complete work-record for one month. He made no reply to repeated requests and gave no explanation for his unwillingness. Tables 8, 9, and 10 (following) present the work-records of the other three ministers for the same week in April 1968.

TABLE 7. FUNCTIONAL MULTIPLICITY & DIVERSIFICATION : A SYNOPSIS

Function	A RURAL LINKED	B COUNTRY TOWN	C SUBURBAN	D NEW HOUSING
WORSHIP : — including SUNDAY & PREPARATION	2 SERVICES p.w. 10.15 12.00) c. 50 Traditional form Quart. Communion School Service weekly.	2 SERVICES p.w. 11.00 (300) 6.30 (30) Trad. form Quart. Comm. 	2 SERVICES p.w. 11.00 (450+) 6.30 (100+) Experimental (p.m.) W. thly Comm. Intercessory Group.	2 SERVICES p.w. 11.00 (250) 6.30 (50) Experimental (p.m.) Bi-monthly Comm. Special m. thly Services : Firming Baptisms Healing School and Hospital Services.
PASTORAL : BAPTISMS -	3-10 p.a. No preparation	27-30 p.a. Visit home.	c. 25 p.a. Hour interview.	c. 50 p.a. Home interviews
WEDDINGS -	8-10 p.a. Rehearsal	c. 12 p.a. Prearranged interviews.	c. 20 p.a. 2 one hour interviews — EMA Booklet.	c. 30 p.a. Hour interview — referred to Mar. Guidance Courses.
FUNERALS -	0-10 p.a. visitation	27-30 p.a. visitation	c. 24 p.a. visitation	0-12 p.a. visitation
VISITATION -	No regular visitation — casual contact.	Systematic — every home in parish ; also bereaved, ill, etc.	Only cases of need — grief, hospitalized, homebound, etc. (Routine visits by Elders)	Only cases of need — grief, ill, etc. (Routine visits by Assistant & Elders).
Misc. -	— Few local problems.	— Problems assoc. with marriage, family, grief, alcoholism — Cooperation with local Services.	— Problems of students and youths. Chaplain to Handicapped Children's School	— Problems of young families — referred to Marriage Guidance. Hospital Chaplain.
EDUCATION :	Catechumens — as need arises ; simple explanation Visits local school.	Catechumens — 3 groups p.a. (6 weeks) S.S. teaching & Teacher training.	Catechumens — 3 groups p.a. (7-10 weeks) Bible Class Adult Study Group Elders' Conf. School Chapt.	Monthly disc. for new members. S.S. teacher training. Elders' Conf. School Chapt.
ADMINISTRATION & ORGANISATION	Congregational admin. & planning Presbytery C'tees Convener G.A. C'tee	" Presbytery Clerk Convener G.A. C'tee Local Education C'tee Meets with Med/Soc. Service Directors.	Staff Meeting Pres. C'tees G.A. C'tee	Staff Meeting Pres. C'tees. G.A. C'tee. Committees for Community Centre " Council Long Community.

TABLE 8. MINISTER B (Country Town) : WORK RECORD FOR ONE WEEK.
(April 1968)

SUN. 21	MON. 22	TUE. 23	WED. 24	THU. 25	FRI. 26	SAT. 27
8.30 BREAKFAST. 9.00 DEVOTIONS PREPARATION 10.00 SUNDAY SCHOOL 11.30 MORNING- WORSHIP (300)	8.00 B'KFAST 8.30 DEVOTION MAIL, PAPERS 9.30 DAY OFF GARDENING /	8.00 B'KFAST 8.30 DEVOTIONS MAIL ADMINISTRATION 10.30 REGIONAL EDUCATION SUB-COMMITTEE (monthly)	8.00 B'KFAST 8.30 DEVOTIONS MAIL etc. 9.15-12.30 SYNOD MEETING (3 p.m.)	8.00 B'KFAST 8.30 DEVOTIONS MAIL etc. 9.30 STUDY PREPARATION 10.30 MINISTERS FRATERNAL (monthly)	8.00 B'KFAST 8.30 DEVOTIONS MAIL etc. 9.30-12.15 SUNDAY PREPARATION	8.30 B'KFAST 9.00 DEVOTIONS MAIL etc. 9.30 FINAL SUNDAY PREPARATION
12.30 INTERVIEWS(2) 1.30 LUNCH 2.30 SUNDAY READING - RELAXATION /	12.30 LUNCH 2.00 GARDENING /	12.30 LUNCH 2.00-5.00 STUDY READING PREPARATION	1.15 LUNCH 2.30 FUNERAL - HOME & CREMATORIUM	12.30 LUNCH 2.00 VISITATION - REGIONAL- HOSPITAL- (8 CALLS)	12.30 LUNCH 2.00 VISITATION - HOSPITAL (4) - HOMES (3)	1.00 WEDDING & RECEPTION
5.30 TEA 6.30 EVENING WORSHIP (30) 8.00 TV READING /	5.00 TEA 6.30 FAMILY - TV READING /	5.00 TEA 6.30 VISITATION - 4 HOMES 9.30 STUDY PREPARATION 10.30. RELAX TV SUPPER (1)	5.00 TEA 6.30 VISITATION - 11 HOMES 10.00 RELAX TV SUPPER 11.30 BED (9 1/2)	5.30 TEA 7.30 TRAINING & PLANNING WITH S. SCHOOL TEACHERS 10.00 RELAX TV SUPPER 11.00 BED (9 1/2)	5.30 TEA 7.00 PRE-MARITAL INTERVIEW 8.00 STUDY PREPARATION 10.30 RELAX READING 11.30 BED. (10 1/2)	5.00 TEA 6.30 COMPLETE PREPARATION 9.30 RELAX TV SUPPER 11.30 BED (10)

TABLE 9. MINISTER C (Suburban Residential): WORK RECORD FOR ONE WEEK.
(April 1968)

SUN. 21	MON. 22	TUE. 23	WED. 24	THU. 25	FRI. 26	SAT. 27
8.30 BREAKFAST 9.00 PREPARATION 10.00 DISC. CLASS 11.00 MORNING WORSHIP (450+) 12.15 INTERCESSORY PRAYER GROUP	8.15 BREAKFAST 8.45 LETTERS ADMINISTRATION 10.30 TOWN - SHOPPING WITH WIFE 11.45 STUDY PREPARATION	8.30 BREAKFAST 9.00 CHURCH 9.15 STUDY 10.30 VISITATION 11.45 STUDY PREPARATION	8.15 BREAKFAST 9.00 COLLECT SECRETARY 9.30 OFFICE - ADMINISTRATION LETTERS PHONE STUDY	8.30 BREAKFAST 9.00 LETTERS ADMINISTR. N STUDY 10.15 VISITATION - HOMES (2) 11.30 PREPARATION	8.30 BREAKFAST 9.00 WALK 10.45 COMMUNITY CENTRE COFFEE MORNING 11.30 GENERAL PREPARATION ADMINISTR.	8.30 BREAKFAST 9.15 PAPERS LETTERS 9.45 GARDENING 10.30 BEACH WITH FAMILY 12.00 STUDY 1.00 LUNCH 1.45 FAMILY 3.00 VISITATION 1 SERIC 2 GRIPS 5.45 TEA 6.30 CUNNING PREPARATION
12.45 COMMITTEE MEETING 1.30 LUNCH 2.00 READING WEEKLY PAPERS PREPARATION 5.15 TEA 6.30 EVENING WORSHIP (100+) 7.45 YOUTH FELLOWSHIP 10.00 HOME - RELAX SUPPER 11.15 BED (9½)	1.00 LUNCH 2.00 DOMESTIC CHOSES 3.45 PLAN EVENING MEETING 4.20 SWIM WITH CHILDREN 5.45 TEA 7.00 STEWARDSHIP COMMITTEE 10.30 SUPPER PHONE CALLS 11.15 READING 12.15 BED (5¾)	12.45 LUNCH 1.45 ASSEMBLY COMMITTEE 3.30 HOSPITAL VISITS 5.30 TEA 6.15 PARISH VISITATION 8.00 LOCAL MINISTERS' GROUP 10.40 SUPPER TV 11.30 BED. (9½)	1.15 LUNCH 2.15 SYND MEETING (3 P.A.) 3.30 LIBRARY BOOKSHOP 4.15 VISITATION 6.00 TEA 7.30 VISITS - 2 ELDER 9.00 ADMININ PHONE CALLS 10.00 SUPPER READING 10.45 BED (8¾)	12.45 LUNCH 2.15 - 5.00 VISITATION - HOSPITALS 5.15 TEA 6.00 VESTRY HOUR 7.30 MEET. SESSION COMMITTEE 9.00 ADULT STUDY GROUP 11.00 SUPPER READING 12.00 BED (10½)	12.45 LUNCH 1.30 LETTER PHONE ADMINISTR. N 3.00 VISITATION - HOMES 5.30 TEA 7.30 CUBS PARENTS' NIGHT 10.00 SUPPER READING 11.30 BED (7½)	12.00 STUDY 1.00 LUNCH 1.45 FAMILY 3.00 VISITATION 1 SERIC 2 GRIPS 5.45 TEA 6.30 CUNNING PREPARATION 10.00 TV READING SUPPER 12.30 BED. (7½)

TABLE 10. MINISTER D (New Housing Scheme) : WORK RECORD FOR ONE WEEK (April 1968).

SUN. 21	MON. 22	TUE. 23	WED. 24	THUR. 25	FRI. 26	SAT. 27
8.00 BREAKFAST 9.15 FINAL PREPARATION 11.00 MORNING WORSHIP - HEALING & BAPTISMS (200+)	7.30 B'KFAST 9.00 SHOPPING 10.00 ADMIN - PREPARATION OF WEEK'S WORK	7.30 B'KFAST 8.45 SCHOOL SERVICE 10.00 HOSPITAL - CHILDREN'S SERVICE 11.00 VISIT (SICK) 11.30 STAFF MEETING	7.00 GARDEN 7.30 B'KFAST 8.15 ADMIN 9.15 BUSINESS - SHOPPING FOR EQUIPMENT 10.15 ASSEMBLY COMMITTEE	7.30 B'KFAST 8.30 GARDEN 9.30 SUNDAY PREPARATION 10.30 HOSPITAL VISITATION (CHAPLAINCY)	7.30 B'KFAST 8.30 SUNDAY PREPARATION 9.30 VISIT (1) 10.30 GARDEN	8.00 LONA PLANNING COMMITTEE
12.45 LUNCH 1.15 - 5.30 ELDER'S CONFERENCE	12.30 LUNCH 1.30 ADMIN - S.S. PICNIC SERVICES FETE 3.00 GARDEN	12.30 LUNCH 1.30 STAFF MEETING (CONT.) 3.00 DESK WORK - LETTERS 4.00 SOCIAL SERVICES WORKING COMMITTEE 5.30 SWIM WITH CHILDREN 7.00 TEA 8.00 VISITATION - 2 HOMES 9.00 CHOIR 10.00 SUPPER READING	12.30 LUNCH 1.30 TV RELAX 2.30 ADMIN LETTERS PHONE 4.50 VISITATION - 4 SICK 5.30 TEA 6.30 VISITATION - 3 HOMES 8.30 HOUSE CHURCH MEETING	12.00 VISIT (SPECIAL) 12.30 LUNCH 1.30 VISITATION - HOSPITAL 1 GRIEF 3.30 RELAX TV 4.30 HOSPITAL 5.30 TEA 6.45 PRESBYTERY SERVICE - INDUCTION 10.15 SUPPER TV	12.30 LUNCH 1.30 STUDY - PREPARATION ADMINISTRATION 2.30 RELAX TV 3.00 FUNERAL 4.15 HOSPITAL 5.00 TEA 6.45 PRESBYTERY SERVICE TO GLASGOW - LONA COMMUNITY PLANNING COMMITTEE (2 PA.) 10.15 SUPPER TV	12.00 FOOTBALL 7.00 TEA 8.00 TV 10.00 FINAL SUNDAY PREPARATION
5.30 TEA 6.15 EVENING WORSHIP (50) - ASSIST. 8.30 PAPERS TV SUPPER	5.30 TEA 6.15 VESTRY HOUR 7.30 KIRK SESSION (MONTHLY) 9.30 COMMUNITY CENTRE COMMITTEE 10.45 SUPPER 11.30 DED (64)	5.30 CHURCH 7.00 TEA 8.00 VISITATION - 2 HOMES 9.00 CHOIR 10.00 SUPPER READING 12.00 DED (10)	11.30 SUPPER 12.00 DED (124)	10.15 SUPPER TV 12.00 DED (94)	11.00 SUPPER TV 12.00 DED (5)	11.00 SUPPER TV 12.00 DED (1)

Each of these ministers fulfils the functions of preacher, priest, pastor, teacher, administrator and organiser, which, of course, overlap at many points. Strictly speaking, each of these capacities embraces an aggregate of varied functions and activities all directed to basically the same objective. The minister's preaching responsibility involves preparation and study. As a teacher he may be involved in catechisms' classes, Sunday School teachers' preparation, Sunday School and Bible Class teaching, study groups, and school chaplaincy. In fulfilling his pastoral responsibilities he may undertake parish visitation, visitation and care of the bereaved, housebound, elderly, and hospitalized, and may act as a counsellor in cases of special need. He may be called on to fulfil administrative and organizational functions at a congregational, parochial, and ecclesiastical level. Despite the supposed centrality of the ministry of the Word, there is almost no limit to the activities which the Church of Scotland parish minister may be called on to undertake in fulfilling his vocational responsibilities. Beyond his professional duties, he is also expected, ideally, to be a family man, whose marriage and family life is above reproach and which stands as a model of a well-ordered, disciplined, "Christian home".⁽¹⁾

Further discussion revealed that these ministers experience several difficulties in attempting to satisfy multiple and divers functional responsibilities. In face of perpetual demands on their time and services these ministers find it almost impossible to maintain a definite series of functional priorities, or to confine their activities to those they personally regard as essential, or to sustain a focal

(1) Based on the Biblical teaching contained in I Timothy 3: 2, 12, and Titus 1: 6. Also see J.O. Dykes (1968), pp. 68-76, who discusses the implications of these passages for the Christian minister's personal family life. This subject will be taken up in the following chapter.

thrust to their ministry. Theoretically, each man has a conceptual image of his central role. In practice, however, they find that they are "constantly on call" and torn in various directions by numerous demands and responsibilities. In consequence, it becomes impossible to sustain a consistent and integrated role as the objectives which they set themselves are swamped by multifarious demands, the use of their time is disrupted and fragmented, and they are reduced to meeting needs simply as they arise without regard to long-term objectives. On the basis of American experience, S.W. Blizzard considers that this is the crux of 'the minister's dilemma':

"The roles which a minister performs in present-day American society are basically equivocal. On one hand, the Church has a traditional set of norms by which he is expected to be guided. On the other hand, the parishioner has a set of functional expectations by which the minister's professional service is judged. This is the minister's dilemma."⁽¹⁾

Certainly these four ministers, between traditional norms, personal goals, and parishioner expectations, find it extremely difficult either to sustain a consistent role or to establish clearly-defined objectives.

According to their own testimony, however, it is also apparent that they are not simply victims of external circumstances or pressures. Ministers B, C, and D all consider that personality characteristics have made some contribution to their role-confusion and functional diffusion. Whatever their rational objectives and concepts of the ministry, each of these men feels compelled to give a positive response to any request for his service or any demands on his time. The problem was articulated by Minister D, who observed: "I have always had the problem of being too conscientious. I feel as though I cannot refuse a request for my time or help so much so, that I don't like to

(1) S.W. Blizzard (1956 b), op.cit. Quoted in The United Presbyterian Church in the U.S.A. (1961), op.cit., p. 30.

take time for leisure, or relaxation, or even for my family. In a way I feel as though my work is never complete at least, not to my own satisfaction and I feel uneasy if I relax." In other words, these men tend to put themselves in the position of being perpetually "on call" and are driven, at least in part, by internal pressures to fulfil a multiplicity and diversity of functional requirements.

Then, secondly, given the external and internal pressures to which these men are subject and given the role-diffusion which then develops, it becomes impossible to adhere to any system of functional priorities. In practice, the relative importance of different functions tends to be lost, as various functions converge and merge at some points and come into conflict at others. Between them, these ministers drew attention to three major areas of conflict. In some circumstances, they find that preaching and pastoral responsibilities are difficult to reconcile as directive and non-directive concepts come into conflict. Conflict between congregational expectations and parochial responsibilities is another frequent source of tension in their experience. This is most significant in the case of the two younger men, both in urban parishes with largely "non-churched" populations for which they feel personal responsibility as parish ministers. Another major source of tension is in the conflict between the minister's professional and private lives, between vocational requirements and family responsibilities. Again, this is felt most keenly by the two younger men, both with young families.⁽¹⁾ These and other conflicts would seem to be the inevitable consequence of role-confusion and functional diversification.

Thirdly, it must be questioned whether any one man is able to effectively fulfil such a diversity of functions, either to the

(1) Compare with the findings on the parish minister's role-conflicts presented by S.W. Blizzard (1956 a), op.cit.

satisfaction of parishioner expectations or to the satisfaction of his personal standards. None of these four ministers had any previous experience or training in the fields of pastoral psychology and counselling, teaching principles and methods, methods of communication, sociology, or business administration. Any understanding and skills which they possessed in these areas had been acquired "in the field", by experience. Minister C, for example, feels particularly inadequate in the realm of pastoral care and considers that basic training in counselling methods would have been invaluable. By contrast, Minister D regrets the lack of training in educational methods. The point seems to be that, in an age of specialization, the parish minister is at a distinct disadvantage. Many of his traditional functions are now carried out by a variety of specialists and, moreover, his theological education does not provide him with the resources or skills to make a worthwhile contribution in these areas. There is the question, of course, whether a parish minister should be a "general practitioner" and accept that position or whether he should attempt to be a specialist in any sense.⁽¹⁾ That is debatable. Until recent years, however, he has had little choice other than to be a general practitioner, except in those cases in which an individual has had previous training and experience in a specialized field.

More opportunities for training in specialist areas have been introduced to the theological curriculum.⁽²⁾ But, characteristically,

(1) Compare with S.W. Blizzard (1956 a), op.cit.

(2) Important additions and modifications have been made to the theological curriculum, especially in the last decade, particularly in the realm of Practical or Pastoral Theology. For example, at least two Faculties of Divinity have introduced Diplomas of Pastoral Studies in recent years (Edinburgh and St. Andrews Universities). Also, students who take Divinity as a first degree are required to spend a further two years undertaking additional education and training in practical spheres. The benefits of these and other developments, however, were not generally available to those men ordained prior to the last decade.

the practical aspects of preparation for the ministry of the Church of Scotland are usually described as "Pastoral Theology" or "practical education" rather than as "practical training", with a theological rather than pragmatic foundation.⁽¹⁾ This is in keeping with the verbal and ideological concept of the ministry of the Word. Technical skills are of secondary importance. This point was stressed in a report of the Education for the Ministry Committee in 1964.⁽²⁾ In addition, this report offered the rather unusual argument that such subjects as sociology and pastoral psychology "are best pursued when men are somewhat maturer in judgment and are already in the field"⁽³⁾: an unusual argument when it is made with reference to men the majority of whom are graduates or who have had previous occupational experience before embarking on theological education.

Whatever the validity of this argument, the fact is that the parish minister, among his many functions, is expected to perform the duties of a pastoral counsellor, teacher, leadership-training instructor, professional youth worker, public relations officer, personal selection officer, social worker, and business administrator. According to the standards of contemporary specializations in these areas, his training for these functions is fairly described as being minimal. On the evidence of two of these ministers, it would seem that some ministers feel at a disadvantage in this respect.

Closely related to this issue, fourthly, is the fact that the parish minister's work often comes into contact with and sometimes overlaps the areas of other professions and community service organisations. In these circumstances interprofessional and interorganizational

(1) Reports to the General Assembly, 1964, p. 521.

(2) *Ibid.*, p. 516 ff.

(3) *Ibid.*, p. 521.

relationships assume some importance. The doctor, psychiatrist, teacher, health visitor, social worker, probation officer, lawyer, and others may well ask whether the parish minister is entitled or even equipped to intrude into their specialist "fields". But it is also possible that the parish minister may provide a valuable liaison between his parishioners and appropriate professional and social services available in his community. This is illustrated most clearly in the cases of Ministers B and D. Minister B, for example, has made a point of establishing close interprofessional relationships with those responsible for medical, psychiatric, and educational services and organisations in the county. He is a member of the local Education Committee and has regular meetings with the Medical and Social Service Directors. Minister D, in addition to Hospital and School Chaplaincy responsibilities, is a member of the local Community Centre Committee and the Community Council. Ministers C and D frequently refer engaged and young married couples to the services and courses offered by the Marriage Guidance Council. This kind of liaison and referral procedure is considered most important by each of these men, as it sometimes happens that they are among the first to be aware of a problem and it is important to direct parishioners to the appropriate services. Whether this is a general practice throughout the Church of Scotland ministry is another question.

Fifth, and finally, it is all too easy to over-emphasize the undoubted problems and conflicts associated with the functional multiplicity and diversity of the parish ministry. In the opinion of these four ministers this characteristic of their work is often a source of frustration and conflict, but it is also often a source of satisfaction and enjoyment. For all the difficulties it presents, each of these men finds the variety of his work a source of continual interest

and periodic pleasure. In fact, according to one man "it is one of the most satisfying and pleasurable aspects of the ministry. There is always something of interest. You're never sure what you will be doing next". Interestingly, none of these men has ever seriously considered leaving the ministry: as expressed by one of them, "I can't imagine a more satisfying or interesting occupation, and I've never entertained the thought of dropping-out not for a moment". One wonders whether these are typical reactions and perhaps whether it may be that the satisfactions more than compensate for the frustrations. It would seem that the parish ministry, at a functional level, certainly has elements of both.

3. INDEPENDENCE AND INDIVIDUAL DIFFERENCES

In theory, the Church of Scotland minister has a large measure of independence, especially within the sphere of his particular parish, and is assured a reasonable degree of security. The parish minister is under no direct supervision and is very much his own manager, although he is answerable to and under the jurisdiction of his Presbytery. Under the jurisdiction of a Presbytery, he is assured of security of tenure and cannot be deprived of his income except as a consequence of disciplinary action. He has equal status with his colleagues in the ministry and with Elders in his Kirk Session, as parity within the ministry and the parity of clergy and laity are fundamental principles of Presbyterian Church Government. Within this structure, the minister has both independence and security in conducting his parish ministry.

The parish minister is then theoretically free to adapt his ministry to local conditions and needs. He is free to determine his own personal objectives in fulfilling his vocation. He is not answerable to an immediate superior or supervisor and is free to plan the use of his time and to determine his own hours of work. In his position, he

is entrusted with the use of the Church's buildings for the purposes of his office and has particular freedom in the realm of worship, which is his sole responsibility. It would seem that the parish minister has considerable freedom to adjust the pattern of his ministry to local needs and latitude to express his personal interests and to utilize his particular gifts. Much then depends upon his personal integrity, self-discipline, and ability to organise his programme. Each five years his ministry and the life of his congregation comes under the scrutiny of a Presbyterial visitation; otherwise, he is relatively independent. Only in the event of blatant laziness, inefficiency, immorality, serious personality defects, or deviant teaching is a minister likely to come under the discipline of his Presbytery; and any complaint about any aspect of his life and work must be brought before his Presbytery in the first instance.

Given this element of independence and security, one would expect significant individual differences to appear in the ministry of individuals. There are interesting individual differences in the ministry of these four men, some of which reflect personal interests and gifts and some of which arise out of local socio-cultural conditions.

Minister A (Rural Linked-Parish), whose ministry follows a traditional pattern based on the ministry of the Word, has a particular interest in administration and is able to devote a large proportion of his time to the affairs of the Kirk's Courts and Committees. With a very small local population, Minister A has comparatively few pastoral duties associated with funerals, weddings, baptisms, and hospitalization. According to his own estimate, very few serious pastoral problems or crises arise in this small rural community and he is therefore free to devote the majority of his time to his preaching, priestly, and administrative activities. As noted, his three colleagues have found it

impossible to confine their activities to such a narrow area.

Minister B (Country Town) has a particular interest in administrative activities, for which he has an undoubted gift, and he has been able to make an outstanding contribution to Church and Community affairs in this respect. At a parish level, he attempts to devote particular attention to preaching and pastoral duties. In its very nature his parish presents many more pastoral responsibilities than that of Minister A, as is evident in the amount of time and care which he devotes to this area of his work. Minister B is also particularly aware of his responsibilities as a parish minister and attempts to carry out systematic visitation of every home in his parish without exception, regardless of denominational and religious affiliations.

Minister C (Residential Suburban) regards his pastoral functions as primary, although the pressure of other demands and the lack of adequate training prevents him from developing this area of his work as he would wish. However, he has a personal interest in the needs and problems of the large academic population, staff and students, in his area and also in the problems of young married couples and of family life. He also has an interest in experimental forms of worship which he is able to express.

Minister D (New Housing Scheme) considers that his primary function, at a parochial level, is administrative and organizational, which is possibly the most radical departure from the traditional concept of the ministry expressed by these men. In addition, he has personal interests in experimental forms of worship, spiritual healing, and the problems of youth and the numerous young families in his parish, all of which have a place within his ministry. He has also become involved in a number of community activities, some of which were initiated by his congregation.

It can be seen that the parish minister is free, if he wishes, to develop the pattern of his ministry along personal lines and according to parochial sociological conditions.

4. FUNCTIONAL HOMOGENEITY

There is reason to conclude, from the evidence of these four cases, that the supposed independence and freedom of the parish minister is largely theoretical or illusory. There is a quite remarkable similarity in the overall pattern of ministry conducted by each of these men. Certainly there are individual differences in emphasis, conceptual convictions, personal interests and attitudes, local contingencies, methods, and the use of time, but none of these really constitute major departures from a common pattern of ministry. It is almost as though each man conducts his ministry according to a predetermined pattern or a traditional role-set (see Table 7, q.v.). Despite the considerable social differences between their parishes and in spite of the personal attributes, interests and attitudes of these ministers, the multiplicity and variety of activities carried out by these men vary little from situation to situation. There is a basic homogeneity in the pattern of ministry conducted in these four cases.

One wonders how this common, homogeneous pattern of ministry is established, conveyed, and introjected by individual ministers. It would appear that Church of Scotland parish ministers are subject to a common process of socialization. S.W. Blizzard has also observed this phenomenon in the experience of American Protestant parish ministers and has commented:

"No matter how different ministers' ideas of what is important in the ministry, they all wind up doing substantially the same thing. It is perfectly apparent how largely the social roles of

Protestant parish ministers are conditioned and defined by the requests of parishioners, the denominational programme, and the culture of the community."⁽¹⁾

The contention is that common socialization is responsible for the role-set and functional homogeneity evident in the American Protestant parish ministry.

From a study of the work of 23 Church of Scotland parish ministers in and around Aberdeen, B. Anderson (1969) came to basically the same conclusion.⁽²⁾ He observed that these ministers, despite personal convictions and interests, tended to be confirmed in a particular life-style and conformed to a traditional pattern of ministry. All these parish ministers, he maintained, define their jobs with respect to the expectations of their congregations and their role-set is informed by pragmatic considerations rather than by theological convictions. He also argued that, in view of their common socialization and the pressure of expectations, these ministers were not likely to be amenable to a rational or radical re-evaluation of their role according to theological concepts and norms. Even those who wished, rationally, to depart from the traditional, established pattern of ministry are not free to do so in fact, but are bound by congregational needs and parochial demands.

On the testimony of these four ministers, a number of factors, in an intricate process of interaction, are involved in the process of socialization which produces a homogeneous pattern of ministry and which drastically curtails the parish minister's independence. These factors could include personal religious background, theological education, traditional structures and procedures, congregational demands, parochial and social expectations, and, most probably,

(1) S.W. Blizzard (1956 b), op.cit. Quoted in The United Presbyterian Church in the U.S.A. (1961), op.cit., p. 30.

(2) B. Anderson (1969), op.cit.

personality characteristics. Theological education, as mentioned, is explicitly designed to maintain and perpetuate the traditional concept of the ministry of the Word and Sacraments. But, as we have also seen, the two younger men, both trained post-war, theologically deviate from that traditional concept. In the experience of these men, congregational and parochial demands and expectations, the Presbyterian system of Church Government, and personality factors have been more potent forces in limiting their freedom to exercise their ministry according to their own ideals and expectations.

In face of the multifarious demands made on their time and personal resources it becomes impossible to maintain a focal thrust to their ministerial activities and it becomes impossible to establish a clear system of priorities or reasonably attainable long-term objectives. Necessity forces the minister simply to perform according to random and often unrelated expectations. In consequence, he is "macerated", his independence confined, and his ministry increasingly diversified and spread over a wide area as he attempts to satisfy ecclesiastical, congregational, parochial, and social expectations. The inevitable result, whatever the individual minister's priorities and objectives, is homogenization.

The parish minister's place within the system of Church government, secondly, tends to expose him to the pressure of such competitive expectations. His status, including independence and security, affords little protection against these pressures. The area of his authority is in fact very limited: he has the right to the use of the Church buildings for the purposes of his office⁽¹⁾ and he has sole responsibility for the conduct of worship and the celebration of the Sacraments.⁽²⁾

(1) Practice and Procedure (1964), op.cit., p. 48.

(2) Ibid., p. 50.

Even his responsibility for worship is circumscribed: forbidden changes of worship are specified, including whatever is "a cause of division" in the congregation,⁽¹⁾ which could be interpreted very widely. The sphere of his ministry is precisely delineated within the bounds of a specific parish.⁽²⁾ The area of his freedom is therefore largely theoretical and conceptual. In practice it is circumscribed. In the congregational structure, with the exception of worship and celebration of the Sacraments, every other aspect of his ministry is subject to a system of democratic decision-making, over which he may exert some personal influence but within which he has no authority as such. The life of his congregation is determined by the democratic decisions of the Kirk Session, Board of Management (or Managers or Deacons' Court), and Congregational Meetings. Although he is the professional religious expert and advisor and accepted leader, he is nevertheless committed to dealing with people on a democratic basis. Within this structure, his personal priorities and objectives are subordinated to the wishes and expectation of Elders, Managers, and Congregational members, which is not infrequently a source of serious tension.⁽³⁾

The parish minister's independence is also relative to the degree of his personal freedom and inner-autonomy. Three of these men in particular feel compelled to give a positive response to any request or demand. As one commented: "I seem to be quite incapable of saying 'No'. My wife tells me that's my greatest weakness"; a significant observation. In varying degrees, these men feel compelled to meet

(1) Practice and Procedure (1964), op.cit.

(2) Ibid., p. 49.

(3) Compare with the findings of R.L. Hudson (1951), op.cit.

every need, to be good-natured in all circumstances, to be models of love, to comply with every democratic decision, and to attain a high standard of excellence in the performance of their duties. One wonders, on their own evidence, whether these men are in fact free to be what they would wish to be.

It would appear that these men tend to be the victims of congregational and parochial expectations, of a democratic decision-making process, and of their own temperaments, inner needs, and good intentions. Each of these pressures evidently makes some contribution to the process of socialization which culminates in virtual conformity to a homogeneous, generally accepted pattern of ministry which has no clearly established focal point and which is not necessarily an expression of theological considerations.

5. HOURS OF WORK

It is difficult to establish the hours of each minister's working week with any real accuracy. Each parish minister in the Church of Scotland is his own manager and organiser. He is also his own supervisor. He is free to decide how many hours he works and when he will work, and no record is kept of his activities. It is simply a matter of his personal integrity and, in these circumstances, the possibilities of excessive overwork or inactivity may both present problems.

From the records of one month's programme provided by three of these ministers it has been possible to calculate approximate estimates of their working hours (Table 11, over). Each of these men expressed some difficulty in determining what constitutes the "work" of the ministry. Some activities are clearly recognizable as "work". But they were unable to decide whether some activities could be properly

TABLE 11: THE PARISH MINISTER'S HOURS OF WORK

	MINISTER B (Country Town)				MINISTER C (Suburban Residential)				MINISTER D (New Housing Scheme)			
	Week	Week	Week	Week	Week	Week	Week	Week	Week	Week	Week	Week
	1	2	3	4	1	2	3	4	1	2	3	4
Administration/ Organization	16 $\frac{1}{2}$	13	24 $\frac{1}{2}$	17	14 $\frac{1}{2}$	12 $\frac{1}{2}$	10 $\frac{1}{4}$	18 $\frac{1}{2}$	10 $\frac{3}{4}$	12 $\frac{1}{2}$	29 $\frac{1}{2}$	26 $\frac{1}{2}$
Preacher/Priest (incl. Worship, Study or Preparation)	21	21 $\frac{1}{2}$	14 $\frac{1}{2}$	21 $\frac{1}{2}$	15 $\frac{3}{4}$	23	13 $\frac{1}{4}$	13	22 $\frac{1}{2}$	26 $\frac{1}{2}$	17	14
Teacher (educational activities)	1	1	1	2	4 $\frac{3}{4}$	6 $\frac{1}{2}$	3	14 $\frac{1}{2}$	4	2 $\frac{1}{4}$	$\frac{1}{2}$	7 $\frac{1}{2}$
Pastoral Activities	11	16	12 $\frac{1}{2}$	19 $\frac{1}{2}$	19 $\frac{3}{4}$	20	7	15 $\frac{3}{4}$	13 $\frac{1}{2}$	12	17 $\frac{3}{4}$	12
(Family/ Recreation/ Leisure)	(27 $\frac{1}{2}$)	(28 $\frac{1}{2}$)	(31 $\frac{1}{2}$)	(20)	(12)	(12)	(11 $\frac{1}{2}$)	(16)	(21)	(36 $\frac{1}{2}$)	(18 $\frac{1}{2}$)	(23 $\frac{1}{2}$)
					+ day	+ day + 3 days			+ day			
WORK TOTAL	49 $\frac{1}{2}$	56 $\frac{1}{2}$	56 $\frac{1}{2}$	60	55 $\frac{3}{4}$	61 $\frac{3}{4}$	33	61 $\frac{1}{2}$	52 $\frac{3}{4}$	53 $\frac{1}{4}$	64 $\frac{1}{2}$	59 $\frac{3}{4}$

described as work or whether they were in fact personal interests and social activities. This problem of job-description was further confused by the fact that a large proportion of their work is carried out privately, in their own homes, and is invisible to the public. For example, the minister's professional responsibilities require time devoted to systematic study, reading, and preparation. But Minister's A and C, in particular, both regard study and theological reading as one of their major personal interests and a source of pleasure, so that the distinction between work and recreation is blurred.

In view of their difficulties in deciding what constituted work, these ministers were not asked to give an estimate of their hours of work. Instead, these three men kept a detailed record of their programmes over a one month period, with the time devoted to particular activities (the records for one of these weeks are presented in Tables 8, 9, and 10, q.v.). The author then calculated the hours of work from these records on the basis that any activity, passive or active, directly related to the minister's official functions comprised his work.

The hours of work for these ministers, for a full working week, range from $49\frac{1}{2}$ hours to $64\frac{1}{2}$ hours (although Minister C worked for a total of 33 hours in one week this included three days holiday to coincide with his children's school holidays), and each of these men works in excess of 60 hours in some weeks. The average hours of a full working week for these men is 57.3, which is consistent with the findings of the Aberdeen study conducted by B. Anderson (1969) referred to earlier.⁽¹⁾ For ministers in the central area of the city the number of hours per week ranged from 40-72 hours and for ministers in the surrounding suburban areas the range was 33-68 hours. The average hours of work per week for the total sample of 23 parish ministers was

(1) B. Anderson (1969), op.cit.

52.5 hours. One is dependent upon the veracity of ministers' own accounts of their work, but it would seem not uncommon for ministers to work from 50-60 hours per week, with occasional examples of extremes on either side of the average.

When a minister's working time is broken down into particular functions and kinds of activity a curious and somewhat unexpected picture emerges. The complaint is sometimes made that a minister's time is absorbed by "administrivia".⁽¹⁾ However, in these three cases the ministers' time is fairly evenly distributed between administration, preaching and priestly functions (including study and preparation), and pastoral activities. A similar pattern emerged from the Aberdeen study, in which the author observed that, contrary to uninformed opinion, parish ministers do not spend most of their time "oiling the machinery" of organizational life.⁽²⁾ According to the Aberdeen inquiry, two-thirds of the minister's time is devoted to pastor, preacher, and teacher functions. In the case of these three ministers, their preaching, pastoral, and administrative activities each occupy approximately one-third of their total working time. There is, obviously, considerable variation and flexibility in the amount of time devoted to particular activities from week to week, even from day to day. It is impossible to establish a consistent pattern, as the minister's work has to be continually adjusted and disrupted as need and circumstances require.

The most surprising fact is the insignificant proportion of time allocated to teaching and educational activities by these ministers. For the purposes of this analysis this group of activities also

(1) Cf. The United Presbyterian Church in the U.S.A. (1961), op.cit., p. 7-8. Also S.W. Blizzard (1956 b), op.cit., found that Protestant parish ministers devoted two-fifths of their working day to administration.

(2) B. Anderson (1969), op.cit.

included the minister's participation in congregational organizations and clubs, in addition to explicitly educational activities. This comes as a surprise when it is recalled that, among the five functions for which he is responsible, the minister is entrusted with "the instruction of the young" and "the preparation of new communicants".⁽¹⁾ But it is quite clear that the teaching function does not play a significant part in the ministry of these men.

On the available evidence it appears that Church of Scotland parish ministers commonly work long hours, usually between 50 and 60 hours per week; although there are undoubtedly exceptions. Contrary to the popular stereotype, the ministry is not a "one-day-a-week job". It also appears that the parish minister's time is evenly distributed over his preaching, pastoral, and administrative functions, although this varies from week to week as need arises.

Basically the same three questions keep recurring. Apropos parish ministers' seemingly long hours of work, with little time for relaxation or recreation, together with their attempts to satisfy a multiplicity of functions and expectations, one wonders whether these common characteristics are necessitated by job requirements, or whether they are imposed by the pressure of external demands and expectations, or whether they are the product of typical personality characteristics and intrapersonal forces. There is no obvious answer, but the questions bear consideration.

6. CRITERIA OF EVALUATION

If the parish minister's role is diffuse and his functions divers then it is inevitable that he should have difficulty in establishing adequate criteria by which to evaluate success or effectiveness in the

(1) Practice and Procedure (1964), op.cit., p. 50.

fulfilment of his vocation. Quite apart from the problems of role diffusion and functional diversification, the ministry in its very nature offers few tangible results or material rewards as a basis for evaluation. In this respect, the position of the parish minister is unlike that of men engaged in almost any other occupation or profession, who usually have some basis on which to measure the adequacy of their work. It has been suggested by some investigators that the lack of criteria for evaluating success or effectiveness and the conflict between denominational success and parochial effectiveness may be significant sources of frustration and tension for parish ministers.⁽¹⁾

These four ministers are clearly conscious of the ephemeral nature of effectiveness in the ministry and each found it difficult to articulate precise evaluative criteria for their own ministries. Minister B summed up their general point of view: "In the ministry, for the most part, you have to learn to live without many rewards. You have to accept that the end results are out of your hands and that you will probably never know the results of all your efforts. All we can do is to use our resources and abilities to the utmost and be content to leave it at that.Every now and then, of course, you have a glimpse, some sign that your work has borne fruit - you learn that a sermon helped someone in a crisis or that you've helped resolve a marital conflict or that you've helped in some other way - it doesn't happen often and it's rarely spectacular; but it makes all your efforts worthwhile". The last phrase may be most significant. It would seem that such "glimpses" are important for the parish minister's emotional satisfaction and that some signs of effectiveness are necessary for the minister's psychological well-being. It would be self-delusion for a minister to

(1) For example see the research findings of S.W. Blizzard, "The training of the parish minister", Union Seminary Quarterly Review, 1956, 11(2), and 1958 (b).

imagine otherwise. Moreover, in the absence of attainable goals and reasonable evaluative criteria, one wonders whether a minister could ever be "content to leave it at that", as Minister B expresses it. In the absence of such objectives and standards, the minister's work has no end, it is never complete, and there is always something more to be done: obviously a potentially dangerous situation.

Minister D shares this general view that the minister has to learn to live without the gratification of material rewards or the satisfaction of tangible, observable results. In keeping with his concept of the minister as one who equips a congregation to exercise their wider ministry, he adds another criterion of success. An effective minister, in his view, "eliminates his own job". In other words, effectiveness is measured by "the degree to which people have evolved and developed to carry on the work of the Church and the extent to which natural leaders have been encouraged to emerge, so that they can do without a minister if need be". He would regard this as his primary objective: to develop a viable, self-reliant community capable of fulfilling a continuing communal ministry, in which his presence as the parish minister would be no longer necessary. This is an interesting criterion, with significant theological and practical implications for the concept of the ministry. But one wonders how such a state is recognized and one wonders, moreover, whether a minister would be able to acknowledge his dispensibility if such a point were reached.

SUMMARY

Four central features stand out from this descriptive consideration of the functional characteristics and structures of the Church of Scotland parish minister's world.

In the first place, the Church of Scotland has a firmly established, traditional concept of the role of a parish minister: he is essentially

and primarily a minister of the Word and Sacraments. However, it has been seen that this role is diffuse when translated into practice and tends to lose its focal thrust. Moreover, we have seen that the two younger men deviate from the norm in significant respects in their personal conceptualization of the ministry. Their understanding of the ministry is distinctly more operational or functional than the traditional image, with its ideological and verbal orientation. Whether these particular cases are representative of a general movement toward a new pattern of ministry remains to be seen.

Secondly, the parish minister is required to fulfil a multiplicity and diversity of functions, including those of preacher, priest, teacher, pastor, administrator and organiser. In consequence, his energy is invested in a wide variety of activities, without a clear centre and without precisely defined objectives. He is compelled, by a variety of factors and forces, to satisfy numerous expectations and to meet many demands from various directions. Under these conditions, it proves extremely difficult to sustain a consistent or coherent role and long-term planning is a virtual impossibility. He is constantly "on call" and it would seem, at least in his own eyes, that his work is never complete.

Then, thirdly, despite differences in the nature of parishes, in spite of variant concepts of the nature of the ministry, and regardless of individual ministers' personal priorities and interests, it seems clear that ministers tend to conform to a traditional, homogeneous pattern of ministry which varies little from situation to situation. Individual differences in the exercise of the ministry, according to local needs or according to ministers' personal convictions and interests, are peripheral. The similarity between the patterns of ministry in these cases is quite outstanding. It is not unlikely that this is the outcome

of a common and intricate process of socialization to which Church of Scotland ministers are subject. Although individual ministers may consciously wish to depart from the traditional pattern, it would seem that a number of subtle and powerful pressures, both external and internal, prevent them from doing so.

It has also been seen, fourthly, that these parish ministers work long hours in the attempt to fulfil divers functions and to satisfy divers expectations. Moreover, they have no clear criteria by which to evaluate the effectiveness or successful completion of their work, on either a short-term or a long-term basis.

Our primary concern in this context is the possible effects of these functional characteristics and structures on the health of individual ministers. Any consideration of their health experience must be conducted against this background and in terms of ministers' life-style.

CHAPTER 7

THE PERSONAL REALM

"It was not merely decent-living, steady-going, average Christians whom Christ sought and selected for His ambassadors and evangelists, but men of strong, ardent love, intense energy, and burning zeal.

..... They must be picked men, men who believe more firmly, love more intensely, and experience mightier impulses than common to serve the Lord.

..... It is to special honour that they are called, and the special dignity implies special sacrifices and special readiness, and ever eagerness to make and welcome the opportunities of self-sacrifice. He must stand on a higher level of spiritual vitality and fervour than ordinary men."

J.S. Wilson (1901).⁽¹⁾

The clear implication of this quotation, selected from numerous examples in textbooks and discussions dealing with the life and work of parish ministers in the Reformed tradition, is that the parish minister is expected to be a qualitatively different kind of person than his lay colleagues. He is expected to possess a greater degree of spiritual excellence, moral rectitude, austerity, fervour, and a greater willingness to accept self-sacrifice than can be expected of "steady-going, average Christians". He is no "ordinary" man; rather, he must be "a man apart"⁽²⁾ and "must stand on a higher level" than "ordinary" men.

These expectations have considerable theological and psychological implications. But, in the first instance, they have a bearing on the minister's personal and private life. The application of this 'double-

(1) J.S. Wilson (1901); op.cit., p. 49-50.

(2) J. Kennedy (1963), op.cit., p. 9-10. .

standard' means that the minister's vocational performance is not simply valuated in terms of his knowledge, insight, technical skills, adequacy and fidelity in fulfilling his professional functions. Inevitably, his professional performance is also judged in terms of his person: his personality, behaviour, and private life. He is expected to be a model of Christian faith and virtue; so that any distinction between his 'office' and 'person' is effectively eliminated and there is no clear demarcation between the professional and personal; public and private areas of his life. In another manual on the minister's duties it has been stated that

"He can never divest himself of his official character, even when not occupied with the duties of office".⁽¹⁾

According to this view, it is impossible to consider a minister's personal life apart from his vocational office or to evaluate his professional adequacy apart from his personal attributes and behaviour.

It would appear, according to the commonly held standards and traditions of the Church of Scotland in particular and of the Reformed tradition in general, that the vocational and personal realms of a minister's life coincide and cannot be differentiated. The requirements of his office impinge upon and intrude into his personal life in important respects and the quality of his personality, faith, and behaviour is a measure of his vocational fidelity and integrity. But what are the effects of this intimate identification of the minister's person with his official office on the personal realm of his life?

1. THE MINISTER'S FAMILY, RECREATIONAL, AND SOCIAL LIFE

In the cases of these four ministers, the personal and private

(1) J.O. Dykes (1908), op.cit., p. 60.

realm of their lives is confined within very narrow limits. Professional duties absorb the vast majority of their time and leave little latitude or opportunity to develop a satisfying family life, to pursue personal interests, or to broaden or enrich their social relationships and activities. As has been seen, these men tend to work long hours, their time is disrupted, it is impossible to construct a reliable and regular programme, they feel compelled to satisfy all demands as they arise, and feel that their 'work' is never complete. Vocational obligations and professional requirements assume primary importance in all circumstances, and the vocational commitments compel these men, on their own testimony, to subordinate personal needs, interests and responsibilities.

From the work records of three of these men, none of them has a regular day off in an average working week. Each of them attempts, with varying degrees of success, to protect Monday as an official one-day holiday but this rarely works out in reality. Unless they take the precaution of being away from home, then they are regarded as being available and demands are made on their time. Other obligations, such as funerals or meetings, also frequently intrude on their "day off". Otherwise, these ministers have no time which they can regard as being their own; they simply take time off when it happens to become available, usually in a few hours at a time. In consequence, the family, recreational, and social aspects of their lives are disjointed and fragmented.

It also appears that it is a fact of a parish minister's life that occupational responsibilities require his attention in the evening. These men can regard few evenings as their own. For instance, in the four week period for which three of these men provided detailed work-records Minister B (Country Town) was engaged in professional activities

on 9 evenings out of 28, Minister C (Suburban Residential) on 18 evenings, and Minister D (New Housing Scheme) on 21 evenings in the month. The two younger men, Ministers C and D, both with young families, were involved in fulfilling ministerial duties on two-thirds and three-quarters of their evenings during this one month period.

If a working day is divided into three natural units (morning, afternoon, and evening) a man would usually be required to work during two of those segments. The work of a parish minister, however, is dispersed throughout a 14 hour period from approximately 9.00 a.m. to 11.00 p.m. It is inevitable that some administrative tasks, meetings, organisational activities, educational groups, and pastoral duties will involve the minister in evening work. That is unavoidable. But these particular ministers do not then feel entitled to use another segment of the day for recreation or purely personal purposes, without serious misgivings or without causing offence to their consciences. In consequence, however, this work-pattern leaves little room for family life, recreation or leisure, which may have equally damaging effects on the minister's well-being.

These ministers find themselves in what amounts to a 'double-bind' situation, which is not simply resolved. On one hand, if they do not fulfil their vocational obligations according to their own expectations, which are considerable, and if they deliberately put work aside in order to satisfy personal needs, they may expose themselves to the hazards of guilt, anxiety, and depression. But on the other hand, if they do not create opportunities to meet their personal needs for a satisfying family life, recreation, relaxation, and normal social relationships, they may become the victims of dissatisfaction, insecurity, resentment and frustration. Ensnared in this 'double-bind' situation, these ministers find it difficult to achieve a reasonable balance between

'work' and 'play', and, more often than not, personal needs for satisfaction and security are subordinated to and sacrificed in the interests of vocational obligations.

This tension makes an impact on the minister's family life. Fear that they have not been able to do justice to their marriage and family life and that their wives and children have been deprived of the attention and affection to which they are entitled is a major source of guilt and anxiety for these men. Family needs definitely take second-place to vocational duties, any plans for family activities are always regarded as being tentative and family members are often disappointed when planned events do not eventuate, and, in face of the pressures and hours of work, the minister may become an absentee husband and father unless he takes appropriate action to safeguard his family life. Such tension between the professional and personal aspects of the minister's life is not so significant in the case of Minister A, who has spent most of his career in rural and small country towns. But for each of his colleagues it is a continual cause of concern. If professional duties arise then these men feel compelled, as a matter of vocational responsibility, to sacrifice family plans, even long-term plans. Minister D is acutely aware of his children's perplexity and resentment provoked by his unavailability; which is difficult to explain or justify when a large proportion of his work is conducted at home and he appears to be available. Although it proves impossible to develop a regular and reliable pattern of family life, each of these men attempts to protect some time during the week for family relationships and activities. Despite these efforts and good intentions, the fact that their family invariably takes second place and the fear that their family members may be deprived of fundamental needs is a source of guilt and tension for these men.

If it is possible, the personal recreational and leisure activities of these men are even more restricted. It is not that they do not have recreational and cultural interests. Minister C, for example, has interests in walking, motoring, cinema, theatre, music, and literature, and frankly says, "Given the opportunity, I could easily and happily be a dilettante. Indeed, that is one of my greatest temptations". Minister D's interests, by contrast, are more physical and practical: swimming, tennis, football spectating, music, and 'do-it-yourself' hobbies. But, these men have few opportunities to pursue or maintain their personal interests. A few hours of leisure have to be snatched simply as the opportunity arises, usually last thing at night or for a few hours in the morning, and their leisure activities are confined to occasional family outings, television viewing, light reading, and gardening. But this aspect of their lives does not appear to be a conscious source of dissatisfaction or resentment for these men. Minister C expresses their common attitude: "My work is really my greatest interest, and it just happens that the ministry gives me ample opportunity to do those things which I most enjoy. For me, the ministry is both work and play".

Social relationships and activities, beyond their immediate family circle, are almost non-existent in the lives of these men. Each man has a large number of acquaintances and his work involves him in a wide-variety of pastor-parishioner relationships, which are friendly but not familiar or intimate. It is important, from their point of view, to avoid familiarity in pastor-parishioner relationships. Some distance must be maintained, otherwise they suggest, there are many pitfalls for the unwary minister. But, in consequence, these men appear to be socially isolated and have very few close, personal relationships outside their intimate family relationships. The social

relationships of Ministers A, B, and D are confined to a few colleagues and, in view of the mobility of the ministry, these relationships are tenuous and contact tends to be lost so that they have become progressively more isolated. In the space of the one month recorded, Minister B's social activities were confined to family outings and Minister D participated in a two-day conference at which he had opportunity to meet with ministerial friends. Minister C is the only exception among these men. He has developed a circle of personal relationships within the academic and professional communities, and he and his wife find opportunity to meet with these friends in a social context at least once a month. In general, however, the social life of these men is extremely limited. It is interesting that both Ministers B and C described themselves as "basically loners" and considered that the social isolation of the ministry presented more serious difficulties for their wives than for themselves.

This is a superficial examination of the personal lives of these parish ministers. A much more detailed and comprehensive examination of personal aspects of parish ministers' lives will be undertaken at a later stage.⁽¹⁾ Four cases do not adequately represent parish ministers of the Church of Scotland; but their experience does suggest that the parish ministers' personal life is circumscribed and restricted in many respects. Vocational obligations and professional duties constantly intrude into their private life and allow little latitude for family life, personal interests, recreation, and social relationships. The reasons for this phenomenon, however, are not immediately apparent. It is certain that the sheer burden of meeting occupational demands, at an ecclesiastical, congregational, and parochial level, imposes limitations on the minister's personal life. It is also

(1) PART IV: Chapters 12 and 13 report the findings of a personal survey of Church of Scotland parish ministers.

highly probable that personality factors, which one of these ministers describes as "over-conscientiousness", are involved; so that these limits are partially self-imposed or are the manifestation of internal pressures and conflicts. The significance of occupational and personality factors received some consideration in the preceding chapter. However, there is also clear evidence that the Church of Scotland parish minister's personal life is narrowly circumscribed by a subtle and comprehensive system of expectations which are imposed on him from many directions. There can be no doubt that such "expectations" comprise a potent, albeit covert, structure of the minister's world and may exercise a profound influence on his personal life and may even have a bearing on the development of his personality.

2. REPRESENTATIVE AND EXEMPLARY IMAGES

The office of ministry in the Church of Scotland is traditionally defined and described in principally theological terms: the minister's central role is to be a Minister of the Word and Sacraments and his primary function is to promulgate the Gospel. However, representative and exemplary images are also operative and the office is frequently wrapped up in a mystique of holiness and respectability. It is, after all, the office of "the Holy Ministry"⁽¹⁾, which presumably requires men with special attributes and qualities. The representative and exemplary roles of the parish minister are implicit, from the outset, in the minister's ordination vow to "engage in the strength of the Lord Jesus Christ to live a godly and circumspect life; and faithfully, diligently, and cheerfully to discharge the duties of your ministry, seeking in all things the advancement of the Kingdom of God".⁽²⁾ He

(1) Practice and Procedure (1964), op.cit., p. 566-7.

(2) Ibid., p. 567.

is required to be a special kind of man; not simply as a man with special "gifts" or knowledge, nor as simply a man with the particular skills necessary to perform specific tasks within the Church, but as a man with uncommon spiritual, moral, and personality attributes.

In the "representative role" the minister represents both God and people.⁽¹⁾ He stands before the people as "the man of God" and represents God's person. But he stands before God as the priestly mediator acting on behalf of the people. Theologically, the concept of the minister as a priestly intermediary between God and man has little place in the traditions of the Church of Scotland. Nevertheless, the priestly imagery attached to the ministry is tenacious. For example, in a standard textbook on the Scottish parish ministry published in the early part of this century it was stated:

"In the most of parishes and congregations the minister is more than the representative of a Church system - he is the system itself, for men will "judge" it through him, and many will also judge the Faith through him".

(G. Anderson, 1911)⁽²⁾.

It is precisely this kind of statement which prompted the jibe that "the new minister is only the old priest writ large".

The "exemplary image" of the ministry probably exerts an even more powerful influence on the ministry of the Church of Scotland than the representative, priestly image. The "exemplary role" requires that the minister should provide a spiritual and moral example as an inspiration to the people.⁽³⁾ Within the Puritan ethos of the Church

(1) The United Presbyterian Church in the U.S.A. (1961), op.cit., pp. 37-40.

(2) G. Anderson, The Scottish Pastor (Blackwoods, 1911), p. 20.

(3) United Presbyterian Church in the U.S.A. (1961), op.cit., pp. 31-36 (Cf. S.W. Blizzard).

of Scotland, there is no doubt that the minister is expected to be "a specimen Christian":

"He stands before the Church and before the public as an embodiment of the Christian ideal, a specimen Christian, from whom men may learn what a Christian ought to be".

(J.O. Dykes, 1908)⁽¹⁾.

This image of the ministry is not only tenacious and persistent but is also pervasive.

The assertion that representative and exemplary images are applied to the Church of Scotland ministry is not based upon a few random quotations from obscure sources. A proliferation of sources could be adduced in support of this contention. Representative and exemplary images of the ministry are promoted and sustained by a number of potent influences in the Church of Scotland: Biblical injunctions and imagery, the theological and ethical standards of the Reformed tradition, traditional denominational practices and procedures especially concerning discipline, standard discussions and textbooks on ministerial life and duties, and parochial and social expectations all serve to reinforce and to preserve these images. Although it is difficult to measure or evaluate, it is not unlikely that these images exert some influence on the personal and private lives of individual ministers.

3. RELIGIO-SOCIO-CULTURAL EXPECTATIONS

There is clear evidence that a double-standard, both spiritual and moral, is consistently applied to ministers of the Church of Scotland by comparison with lay members of the Christian community. He is expected to be no ordinary man, nor to be simply an average, decent-living Christian for that matter, as is clearly expressed in the quotation with which this chapter commenced. This double-standard appears from many sources.

(1) J.O. Dykes (1908), op.cit., p. 53.

(i) Biblical teaching is of primary importance in the Reformed tradition: the Word of God as contained in the scriptures is "the supreme rule of Christian faith and life"⁽¹⁾, a conviction to which each minister of the Church of Scotland subscribes. It is, therefore, to be expected that Biblical injunctions, exhortation, and advice would be invoked to substantiate and justify the double-standard as it applies to the ministry.

The details of the evolution of official offices in the early Church, as recorded in the New Testament, are the subject of dispute.⁽²⁾ However, it is reasonably safe to offer two generalizations which are relevant in the context of this discussion. It is apparent, in the first instance, that special functions and services were recognized in the early Church. Individual members of the Christian community fulfilled those functions for which they had special "gifts" (I Cor. 12: 4-14, 27-31; 7: 7; 14: 3; 29-33; Eph. 4: 4, 7-12, 16; Rom. 12: 4-8; I Peter 4: 10); individual organs of "the body" carried out those functions for which they were specifically endowed (I Cor. 12: 4-31). Whether these special "ministries", such as preaching, teaching, prophecy, healing, administering, or speaking in tongues, were officially established by a process of election or whether they arose spontaneously

(1) Practice and Procedure (1964), op.cit., p. 567.

(2) For examples of the discussion see J.K.S. Reid (1955), op.cit.; T.W. Manson (1948), op.cit., and (1959), op.cit.; J.O. Dykes (1908), op.cit., pp. 1-8. For an examination of the ministry in the Reformed tradition see J.L. Ainslie, The Doctrine of Ministerial Order in the Reformed Churches of the Sixteenth and Seventeenth Centuries (T. & T. Clark, 1940).

by popular consent and public recognition is open to question.⁽¹⁾

However, whether these ministries were formally established as "offices" or whether they were simply recognized by popular consent, there was no qualitative distinction between them. The only difference was functional and, for the purposes of recognition, the only requirement was that an individual member of the Christian community should have the necessary "gifts" to fulfil a specific function and to provide a particular service.

By the second century of the Church's history, if not before, a qualitative distinction had been established, incorporating a double-standard. In the picture of the Church's life provided by the Pastoral Epistles it is clear that those who filled special offices, variously described as ministers, elders, presbyters, and bishops, were expected to possess unusual spiritual and moral qualities in addition to any functional "gifts" they might possess. (I Tim. 3: 1-13; 4: 6-16; 5: 17-22; 6: 11-14; II Tim. 2: 1-7, 15, 22-26; 4: 1-5, Tit. 1: 5-7; 2: 1, 7-8). These letters manifest a particular interest in the respectability of the Church's officials and are more concerned with the minister's personality, temperament, and moral attributes than with the function or content of the ministry. Attention is focussed on the moral level and character of those who hold office⁽²⁾: as J.K.S. Reid observes,

"The real interest of the Epistles is directed to the moral qualifications of those who hold office, not to the nature of the office which they hold."⁽³⁾

(1) See J.K.S. Reid (1955), op.cit., pp. 4-10. Also compare with J.O. Dykes (1908), op.cit., pp. 1-8. J.K.S. Reid argues that the concept of a formal "office" was present from the start and that the principle of democratic election was established early in the Church's history (Ibid., pp. 8-10).

(2) J.K.S. Reid (1955), op.cit., p. 27-8 (Cf. Streeter).

(3) Ibid., p. 27.

It is quite clear that an exemplary dimension has been added to the functions of the ministry. Official office bearers are "to set the believers an example in speech and conduct, in love, in faith, and in purity" (I Tim. 4: 12) and are to be "examples to the flock" (I Peter 5: 3).

These letters imply that the ministry comprises a moral and spiritual elite, set apart from the Christian in general by special personal qualities and to whom special standards apply, part of whose function it is to inspire the rest of the community by personal example. These exemplary and inspirational images, based on Biblical precedents, are assumed as being normative for the Church of Scotland ministry.

(ii) In the Reformed tradition the minister's personal attributes are of secondary importance to his preaching office and to his function of proclaiming the Gospel. The principal consideration is that he should have the gifts necessary to fulfil this office. However, the exemplary and inspirational images of the ministry, derived from Biblical allusions, have had a powerful influence on the Reformed tradition.

Calvin, for example, who had a considerable influence on the Reformation in Scotland, placed great emphasis on the office and functions of the ministry of the Word within the context of the total ministry of the Church.⁽¹⁾ He considered, however, that this office was not only functionally different but should also be qualitatively different from any other form of ministry, and that those who held this prestigious office⁽²⁾ should be subject to a special value-system.

(1) J. Calvin, The Institutes of the Christian Religion (S.C.M. 1959), Articles IV/III/i-xvi, pp. 1053-1067.

(2) Ibid., IV/III/iii, p. 1055.

This double-standard is made explicit in Calvin's discussion of ecclesiastical discipline: there is, he states, a common discipline which applies to the people and a special discipline which applies to the clergy.⁽¹⁾ More should be expected of the clergy than of the laity and the clergy should be stricter with themselves than with other people,⁽²⁾ and it is implied that the minister should be an exemplary model of what a Christian ought to be.

This principle was firmly incorporated in the standards and practices of the Reformed Church in Scotland from its very inception. In the First Book of Discipline (1560) it was asserted that

"Commandment shall be given ... that he will walk in the presence of God so sincerely, that the graces of the Holy Spirit may be multiplied in him; and in the presence of men so soberly and uprightly that his life may confirm in the eyes of men, that which by tongue and word be persuaded unto others",⁽³⁾

and to this end special standards for ecclesiastical discipline were established in detail,⁽⁴⁾ with reference not only to ministers themselves but also to their "wives, children, and familie".⁽⁵⁾

Stringent standards of appearance, conversation, manner, and behaviour were expected of ministers in the Scottish Kirk under Knox and Melville. With reference to the development of Puritanism in the Scottish Reformed Church and with particular reference to the deliberations of the 1578

(1) J. Calvin, The Institutes of the Christian Religion, op.cit., IV/XII/i, p. 1229.

(2) Ibid., IV/XII/xxii, p. 1248.

(3) Compendium of the Laws of the Church of Scotland (2nd edition, 1837), p. 53 (Art. IV/3).

(4) Ibid., p. 81-90 (Art. IX).

(5) Ibid., p. 89.

Assembly, W.S. Provand has observed:

"At first it was the ministers who were expected to display a preternatural solemnity, and if they wished a reputation for sanctity, never to be seen to smile, but to mingle sighs and groans with their conversation".⁽¹⁾

The minister's "life, manners, study, and diligence" were to be subjects of public scrutiny and each Kirk was to submit an annual report to the Superintendent on his bearing in these respects.⁽²⁾

No area of his life was private or safe from critical appraisal.

A comprehensive value-system, applying special standards to the minister's personality, conversation, appearance, temperament, recreation, social interests, and family life, has been consistently maintained in the disciplinary procedures of the Church of Scotland and still applies today. The Form of Process (1707), which is normative for disciplinary procedures in the Church of Scotland,⁽³⁾ applies special standards and procedures to ministers and states:

"The credit and success of the gospel much depending on the entire credit and reputation of ministers, their sound doctrine and holy conversation, no strain thereof ought lightly to be received".⁽⁴⁾

Any libel or charge against a minister is, therefore, a matter of great importance and requires special care and consideration.

(1) W.S. Provand, Puritanism in the Scottish Church (Alex Gardner, 1923), p. 80.

(2) Compendium of the Laws of the Church of Scotland (1837), op. cit., p. 88-9.

(3) Ibid., p. 155 ff. Also, for further elaboration and examples, see 1889 Act XIX, "Act on Forms of Procedure in Trial by Libel and in Causes generally", Acts of the Assembly 1887-1894.

(4) Ibid., p. 170.

It is implied throughout the standards of the Reformed tradition, as embodied in the Church of Scotland, that a minister is more than an individual member of the Christian community fulfilling a particular function for which he has the necessary gifts; he is, in both a spiritual and moral sense, a qualitatively different kind of "organ" within "the body". He, more than any other member, should manifest the "marks of grace" and "the fruits of the Spirit"; or, to put it the other way around, it is implied that what is regarded as acceptable and normal in the lay Christian is for some reason inadequate, offensive, or even reprehensible in the minister.⁽¹⁾

(iii) From an examination of standard discussion and textbooks on the life and work of the minister, invariably written by ministers themselves and presumably as guidance of potential aspirants to the ministry, it would seem that the exemplary image of the ministry has lost little of its power in the Church of Scotland. If it is possible, they reinforce this imagery and perpetuate the principle of a double-standard which differentiates clergy and laity. Consider, for example, the following assertions:

"They must be picked men, men who believe more firmly, love more intensely, and experience mightier impulses than common to serve the Lord.

... He must stand on a higher level of spiritual vitality and fervour than ordinary men".

J.S. Wilson (1901).⁽²⁾

"He is a selected representation of how a Christian ought to act".

J.O. Dykes (1908).⁽³⁾

(1) J.O. Dykes (1908) op.cit., p. 52, 60, articulates precisely this notion.

(2) J. S. Wilson (1901), op.cit., p. 50.

(3) J.O. Dykes (1908), op.cit., p. 52.

"He needs to be a man whose very presence among his people has a helpful effect, and whose own character has a spiritually healing influence."⁽¹⁾

... People naturally expect a loftier ideal in the ministry than in other walks of life, and that expectation should help the minister to keep true to his high calling."

G. Anderson (1911).⁽²⁾

"The man of God can best inspire his people by setting them a good example."

P.E. Gresham (1954).⁽³⁾

"A Minister should convey the awareness of living close to God. It is a spiritual demand that he be a man apart."

J. Kennedy (1963).⁽⁴⁾

The exemplary image of the ministry, implying a grandiose ideal of moral and spiritual superiority, runs throughout these and many other textbooks dealing with the minister's life, character, and duties.⁽⁵⁾ According to one of these writers, people "naturally expect" more of a minister; but just why this should be natural or taken for granted, or why it should be natural to expect more of a minister than any other committed member of the Christian community is not explained. Certainly no theological foundation for this expectation is offered. But the writer indirectly alludes to the sacred aura and mystique of the "Holy" man when he suggests that a minister should be "inspired and uplifted by the instinctive reverence of all for the man of God";⁽⁶⁾

(1) G. Anderson (1911), op.cit., p. 20.

(2) Ibid., p. 149.

(3) P.E. Gresham, Disciplines of High Calling (The St. Andrew Press, 1954), p. 81.

(4) J. Kennedy (1964), op.cit., p. 15.

(5) In addition see R.C. Gillie, The Minister in the Modern World (A. & C. Black, 1923) and W.A. Brown, The Minister: His World and His Work (T. & T. Clark, 1937).

(6) G. Anderson (1911), op.cit., p. 1.

an observation which could stimulate all kinds of theological, anthropological, sociological, and psychological speculation.

(iv) The Church of Scotland minister's status and functions are not confined to his position within the Christian community. As an official representative of the national religious institution, he also has a socio-cultural status and function. However, the nature of this status and the social expectations which are associated with the minister in the context of Scottish cultural traditions are less easily identified or described. There is no doubt, however, that his behaviour, attitudes, and beliefs are subject to public exposure and scrutiny.

Some indication of the social expectations to which the parish minister is subject may be gained from the fact that, in the two year period between June 1968 and June 1970, a national daily newspaper published no fewer than 82 articles concerning the personal attitudes, beliefs, and behaviour of Church of Scotland ministers. These articles, on average a little more than three per month, usually appeared under dramatic, eye-catching captions, sometimes bordering on the histrionic:

"Ban this preacher! We quit, say eleven elders";

"Minister who quit is still 'out in the cold'";

"Kirk's gang-buster quits Easterhouse";

"The minister who is Celtic's biggest fan";

"A minister's advice: Live and let love!";

"Eighty not out! Why Mr. Wright ministers on past his jubilee";

"'Whisky parson' faces storm";

"Football by minister on Sunday 'disgraceful'";

"Vicious rumours - by Kirk minister";

"How lonely a place is the pulpit";

"Should you offer the minister a drop of the Auld Kirk?";

"Pay up or I'll die, says minister";

"Rebel Rev. fights along the line";

"Ex-padre quits parish and ministry";

"The busy minister must rest";
and "Minister's son banned 5 years".

Only Members of Parliament, local government officials, and sports and entertainment figures appear to be subject to the same public scrutiny and exposure in Scotland. The assumption seems to be that the personality, beliefs, and behaviour of Church of Scotland ministers are measured by some generally accepted, non-explicit standards and that any departure or deviation from the 'norm' constitutes 'news' and is a subject of public interest. The expectations hidden within these assumptions are considerable. Whether they exert any influence or place any restrictions on the personal lives of individual ministers, or whether ministers are even aware of these expectations cannot be determined without more intensive investigation.

It is quite clear that the person and office of the Church of Scotland minister are measured by a complex and comprehensive set of religio-socio-cultural expectations, which apply to his personality, temperament, spiritual and moral attitudes and attributes, personal behaviour, social relationships and activities, and even to his marriage and family life. It would not be surprising if these external expectations served to place some constrictions on the minister's personal and private life. Three themes, each with far-reaching theological and psychological implications, keep recurring in all the sources and statements dealing with the minister's personal life which can be briefly reviewed at this stage.

4. SELF-DISCIPLINE AND SELF-DENIAL

(i) The Minister's Person and Office

The first of these emergent themes is the close identification of the minister's person with his official office. His person and

office are inseparable, so that the office becomes the person and the person becomes the office. The representative and exemplary images of the ministry imply that the credibility of the individual's ministry, and to some extent the credibility of the Gospel and of the Christian community, is contingent upon and measured in terms of the minister's person. Sometimes this is made quite explicit: in some measure, "the credit and success of the Gospel" depends upon "the credit and reputation of ministers" (Form of Process, 1707)⁽¹⁾, the minister "is the system" and men "will judge it through him, and many will also judge the Faith through him" (G. Anderson, 1911)⁽²⁾, he is "a specimen Christian" and his best contribution is to provide "a moral influence" (J.O. Dykes, 1908)⁽³⁾, and he can "best inspire his people by setting them a good example" (P.E. Gresham, 1954)⁽⁴⁾. The minister, as has been suggested elsewhere, is put into the position of "going bail" for the commitment and moral character of the Christian community.⁽⁵⁾ Where there is no clear line of demarcation between the minister's person and office it is inevitable that the quality of his personal life and character becomes a measure of the fidelity and adequacy of his vocational life and, conversely, an evaluation of his vocational responsibility and professional proficiency amounts to a critical self-appraisal and self-judgment.

The identification of the minister's person and office does not

(1) Compendium of the Laws of the Church of Scotland (1837), op.cit., p. 170.

(2) G. Anderson (1911), op.cit., p. 20.

(3) J.O. Dykes (1908), op.cit., p. 53-4.

(4) P.E. Gresham (1954), op.cit., p. 81.

(5) United Presbyterian Church in the U.S.A. (1961), op.cit., p. 37.

simply hinge upon his conduct. Certainly it is expected that his conduct should be reputable and "above reproach" (Cf. I Tim. 3: 2-7; Titus 1: 5-9)⁽¹⁾. It is further expected that his personality and temperament should conform to, or at least match-up to, fairly specific requirements. Certain personality traits and temperamental dispositions are frequently presented as being desirable and appropriate attributes of the Scottish parish minister. The unmistakable implication is that the parish minister is supposed to possess or acquire personality characteristics, with specific features, which are considered appropriate to his office.

The most explicit example is provided in J.O. Dykes' examination of "The Christian Minister and His Duties"⁽²⁾, admittedly published early in the century but exemplifying a recurrent theme.⁽³⁾ The writer gives detailed consideration to "Ministerial Character" and "Ministerial Manners"⁽⁴⁾, making frequent reference to Biblical requirements, and the resultant picture allows little room for individuality or individuation. The major test of a man's vocational integrity, in this view, is that he should manifest a fear of being unworthy or presumptuous, a self-effacing attitude, and a desire "to be a spiritual success".⁽⁵⁾ The minister should then possess "a grave and serious frame of mind", "a studious and quiet disposition", with an inclination "to be severely temperate" and revealing "a gravity of deportment" which excludes

(1) J.O. Dykes (1908), op.cit., p. 56.

(2) Ibid.

(3) For example, G. Anderson (1911), op.cit., p. 148-53; J.C. Wilson (1901), op.cit., p. 38-41; W.A. Brown (1937), op.cit., p. 240; J. Kennedy (1964), op.cit., p. 15.

(4) J.O. Dykes (1908), op.cit., pp. 51-64.

(5) Ibid., pp. 32-35.

undue levity⁽¹⁾. It is desirable that he should possess "a gentle and pacific temperament", "habitual affability", and a developed capacity "to meet all opposition with patience", and in all his relationships he is bound "to be everyone's friend"⁽²⁾. It is most important that he should not be "greedy or a lover of money" and should not covert worldly success or material gain⁽³⁾; and it is necessary that his family should be willing to accept and share the material sacrifices required of him⁽⁴⁾. A combination of "prudence and self-control", of moderation and restraint are necessary attributes, and he should have "habitual self-command" over every aspect of his personal life⁽⁵⁾. This writer sums up textbook advice to ministers:

"For instance: in dress the pastor is told not to be singular or attract observation, but to wear what good society expects to be worn by men of his profession ... In conversation, he is counselled to speak little rather than much; quietly rather than loudly; to argue seldom and wrangle never; to be sparing of slang; to jest playfully, not bitterly; and never to point jests with Scripture or subjects connected with his calling. As to demeanour; gravity tempered with habitual affability or accessibility, and relieved upon occasion by innocent playfulness, is what the authorities recommend. Such counsels are not amiss."⁽⁶⁾

Indeed, it would seem that the advice of the so-called 'authorities' leaves little room for singularity in any respect. The parish minister

(1) J.O. Dykes (1908), *op.cit.*, p. 55.

(2) *Ibid.*, p. 55, 64-5.

(3) *Ibid.*, p. 56.

(4) *Ibid.*, p. 72-3.

(5) *Ibid.*, p. 55.

(6) *Ibid.*, p. 62.

is expected to be "such a man as becomes his office"⁽¹⁾, and Dykes suggests that the minister who "affects the layman", indulges in "abandon of manner" or "eccentricities of gait", wears "unclerical attire", uses "loud bold speech", or who expresses "effusive demonstrativeness" or "excessive jocosity" betrays "indifference to the sacredness of his calling"⁽²⁾.

The ideal 'ministerial character', which is considered appropriate or becoming to the office of ministry, is clearly delineated. Specific traits are regarded as being desirable and normative. One wonders whether and to what extent individual ministers feel obliged or constrained to conform to this 'image', at least for the public performance of their duties.

The underlying assumption seems to be that a minister, by his very calling, enjoys an unusual relationship with God and the quality of this spiritual relationship should be manifest in specific personality characteristics. He is "a man of God" and this should be immediately apparent in his personality, temperament, personal relationships, conduct and deportment: as one writer suggests, "he should convey the impression of living close to God"⁽³⁾. Having this special relationship, he should then be less "earthbound";⁽⁴⁾ which is taken to mean that he should be able to forego many otherwise normal needs for satisfaction and security (as should his family), he should have a greater propensity to tolerate a large degree of solitude and

(1) J.O. Dykes (1908), *op.cit.*

(2) *Ibid.*, p. 61.

(3) J. Kennedy (1964), *op.cit.*, p. 15 and J.S. Wilson (1901), *op.cit.*, p. 24-27.

(4) J. Kennedy (1964), *op.cit.*, p. 10.

apartness, and he should have a special capacity for piety and devotion. The quality of his spiritual life and his relationship to God is of primary importance, and he should therefore be a distinctive type of person. He, in turn, then becomes a "pattern to be imitated":⁽¹⁾ an exemplary model of Christian faith and behaviour. But to become this he must exist at a different level from the common and must acquire and demonstrate the marks of 'holiness':

"It is an inspiring thought that a man has been honoured by the divine Master. ...That consciousness must tend to breathe a sense of distinction and elevation around the entire field of ministerial life and action".

(J.S. Wilson, 1901).⁽²⁾

This theme, identifying the minister's person and office and promoting a distinctive ministerial character, runs throughout manuals dealing with the minister's life and work.⁽³⁾ It is not appropriate to consider the many theological and psychological implications of this theme at this stage of our discussion. Whether the concept of a ministerial personality type has any relevance for the health of Church of Scotland ministers has yet to be determined. Nor is it possible to establish whether this concept is imposed from without or whether it is self-imposed; but it is interesting to note that discussions of the minister's life and work are invariably produced by ministers themselves. But, at this point, it must suffice to note that this concept, supported by Biblical

(1) J.O.Dykes (1908), op.cit., p. 21 (Cf. I Cor. 11:1, 4: 16; I Thess. 1:6).

(2) J.S. Wilson (1901), op.cit., p. 56.

(3) It would be an interesting and possibly illuminating undertaking to construct a personality profile on the basis of the textbook recommendations.

teaching, influential theological perspectives, and denominational traditions, is a not insignificant aspect of the minister's world.

(ii) Personal Satisfaction and Responsibility

The second theme which comes through is the stress laid upon the importance of exercising responsibility in the area of physical habits, standards of hygiene, relaxation and recreation, and social relationships. It is not expected that the minister should be totally "other-worldly" and completely devoted to spiritual concerns. It is part of his Christian responsibility to ensure that he gains adequate sources of satisfaction and security in his personal life and to take appropriate precautions to safeguard his health. Such responsibility is an expression of his vocation, because he can "serve God better by keeping his own health".⁽¹⁾

The standard textbooks give detailed attention to the minister's responsibility for preserving his physical and psychic health.⁽²⁾

As a matter of self-discipline, he should avoid either self-neglect or self-abuse by gaining adequate nourishment, relaxation, and sleep and by avoiding mental or physical inactivity. He should exercise special caution in avoiding detrimental physical habits or addictions, and, in particular, should set an example of abstinence in regard to smoking and the consumption of alcohol.⁽³⁾ It is most important, for his emotional well-being, that he should recognize his personal limitations, his destructibility and dispensibility, and plan the use of his time to allow adequate opportunity for relaxation and

(1) R.C. Gillie (1923), op.cit., p. 117.

(2) See J.S. Wilson (1901), p. 58-9; G. Anderson (1911), op.cit., p. 151-2; J. Oman (1928), op.cit., p. 5-9; R.C. Gillie (1923), p. 110-119; J. Kennedy (1964), op.cit., p. 64, 130.

(3) Reports to the General Assembly, 1958, p. 463-70; 1959, p. 401-2; 1964, p. 347-8.

recreation. J. Oman, for example, taking a commonsense view of the minister's life, comments that "burning the midnight oil is mainly self-deception"⁽¹⁾ and recommends that the minister should put aside his professional duties for one day in seven and for some period of each day.⁽²⁾ The same writer emphasizes the dangers of ministerial isolation as a potentially harmful occupational hazard and the importance of establishing satisfying social relationships.⁽³⁾ If he is to avoid isolation and to gain satisfaction for his need of personal relationships, then, according to Professor Oman, the minister needs to continue to be a man and not a parson.⁽⁴⁾

The underlying principle is that the minister should regard his body as "a temple of the Spirit" (I Cor. 3: 16-17; 6: 15, 19-20; II Cor. 6: 16; Rom. 12: 1; 6: 13; Eph. 2: 21-22; Col. 1: 21) for which he has personal responsibility. As a responsible steward of his resources the minister should not neglect basic physical and personal needs. Furthermore, the eschatological perspective of his faith should be the basis of all his activities and, from this perspective, the minister need not drive himself beyond the bounds of endurance and need not be overwhelmed by guilt or depression. Within the context of his faith, the minister should be able to accept a realistic appraisal of his limitations.

(iii) Self-denial and Self-renunciation

Over against the theme of personal responsibility in satisfying basic needs, it is also made clear that the satisfaction of such

(1) J. Oman (1928), op.cit., p. 7.

(2) Ibid.

(3) Ibid., p. 4-5.

(4) Ibid., p. 4.

personal needs should never take precedence over or interfere with the obligations of the minister's office. The minister's vocational responsibilities and professional duties have a prior claim on his time and energy and should have priority over every aspect of his life.⁽¹⁾ To this end, the minister is expected to subordinate his personal needs to vocational demands and to accept "self-denial" as a fundamental principle of his life. According to one of these writers, the minister should not only accept the necessity of self-sacrifice but should actively seek and welcome opportunities for self-sacrifice.⁽²⁾ This is the third emergent theme: the theme of self-denial and self-renunciation, which should characterize every aspect of the minister's personal life.

The principle of self-denial is comprehensively and consistently applied to every aspect of the minister's life. Relaxation and recreation are essential to his health, but recreational activities should be restrained and controlled. In this area of his life he should demonstrate habitual self-control and should "keep a firm grip on himself".⁽³⁾ Some pleasures and recreational activities should be avoided as being unbecoming to the minister's office.⁽⁴⁾ Prudence and self-control should be apparent in the minister's walk and conversation, dress and deportment, demeanour and emotions, recreations and pleasures. In each area the minister should be

(1) See J.S. Wilson (1901), *op.cit.*, p. 49-50; G. Anderson (1911), *op.cit.*, p. 148-52; J. Oman (1928), *op.cit.*, p. 21; J.O. Dykes (1908), *op.cit.*, p. 21, 57-64; P.E. Gresham (1954), *op.cit.*, p. 155-8.

(2) J.S. Wilson (1901), *op.cit.*, p. 50.

(3) G. Anderson (1911), *op.cit.*, p. 152.

(4) Cf. J. Calvin, *op.cit.*, p. 1248 (Art. IV/XII/xxii).

prepared to practise self-denial, in the sense of sacrificing his personal needs and inclinations, and should demonstrate stringent self-control in the interests of fulfilling his vocation.

The minister's marriage and family life is also subject to the principle of self-denial. It is preferable that the minister should be married (I Tim. 3: 2, 11; Tit. 1: 6)⁽¹⁾, a strong tradition within the Church of Scotland, although this is not required. The importance of his family life, however, is rarely considered in terms of his personal satisfaction and security. Greater attention is given to the minister's marriage and family life as an aid to his office: this aspect of his life may contribute to the healthy development of the minister's character; as a confidant and friend, the minister's wife may provide valuable assistance and support in his ministry; experience as a family-man should enhance the minister's understanding of the problems of others; and his family life may serve as an exemplary model of a Christian home and his children as "patterns of careful upbringing".⁽²⁾ Moreover, the minister's family life should not be allowed to take precedence over his ministry. His wife and members of his family should expect and accept the inevitable sacrifices involved in a minister's life⁽³⁾ and the minister himself should be prepared to sacrifice family responsibilities in order to carry-out professional duties:

"A minister who shirks arduous or hazardous duties in order to spare his wife anxiety or shelter his child from infection, is not, I am afraid, unheard of; and the too cosy home may easily grow seductive to an indolent temper."

(1)

(2) J.O. Dykes (1908), op.cit., p. 68, 75-6.

(3) Ibid., p. 68-9, and J. Kennedy (1964), op.cit., p. 130-2.

(4) Ibid., p. 69.

Furthermore, as has been noted, the disciplinary standards and procedures which apply to the minister are equally applicable to his wife and members of his family.

Social relationships, likewise, are considered necessary for the minister's health. But, in his position, he is bound to be "everyone's friend" without distinction or partiality and it is necessary for him to be prudent and cautious in all his relationships:

"It is safer to err on the side of reserve or over-caution, at least until he has felt his ground."⁽¹⁾

The minister's aim in all his social relations and activities should be to win people's respect and there ought to be, therefore, reserves and restraints in his relationships.⁽²⁾ The minister ought to deny himself the need of a personal confidant, confessor, or pastor because "the only safe and adequate confessor for the sins of a minister is God".⁽³⁾ Indeed, an uncommon degree of seclusion, solitude, and privation is necessarily "involved in becoming a spiritual athlete"⁽⁴⁾ and it is necessary for the minister to observe a measure of apartness if he is to deepen and enhance the quality of his spiritual and devotional life.⁽⁵⁾

The theme of self-denial and self-renunciation, as it is applied to the Church of Scotland minister's life, could be pursued at considerable length. The standard textbooks on the minister's life

(1) J.O. Dykes (1908), *op.cit.*, p. 64.

(2), R.C. Gillie (1923), *op.cit.*, p. 125.

(3) P.E. Gresham (1954), *op.cit.*, p. 158.

(4) *Ibid.*, p. 160.

(5) See G. Anderson (1911), *op.cit.*, p. 6-8; J.O. Dykes (1908), *op.cit.*, p. 45-8; P.E. Gresham (1954), *op.cit.*, p. 156-8; J. Kennedy (1964), *op.cit.*, p. 15.

and work apply a uniformly puritanical interpretation of the concept and invest it with specific content in relation to every aspect of the minister's life, professional and private. The principle of self-denial, together with allied themes of self-renunciation, self-crucifixion, and self-mortification, has a central place in the Biblical perspective of the Christian life (Mk. 8: 27-9: 1; Matt. 10: 38-39; Lk. 14: 27, 17: 33; Ju. 12: 25; Rom. 6: 6; II Cor. 13: 4; Gal. 2: 20, 5: 24, 6: 14; Col. 3: 5 ff, 3: 12; Eph. 2: 1, 4: 1-3, 4: 22 ff) and its interpretation has implications for personal health and wholeness which cannot be ignored.⁽¹⁾ The understanding of self-denial within the Reformed and Presbyterian tradition has undoubtedly been influenced by Calvin's notable essay on this theme.⁽²⁾ Although Calvin offered important qualifications in the course of his argument, he placed great stress upon self-renunciation, self-abrogation, and self-sacrifice, not as an expression of stoicism but as an imitation of Christ's example of self-sacrifice,⁽³⁾ which is set as the ideal and primary characteristic of the Christian's life. The acceptability and healthiness of the Pauline and Calvinist interpretation of self-denial has been challenged on both theological and psychological grounds. It is premature, at this point of our inquiry, to enter into this discussion without closer examination of the health and personal life of Church of Scotland ministers. However, it would appear that the concept of self-denial, as it has been understood

(1) Cf. P. Tournier (1954), *op.cit.*, p. 238-41.

(2) J. Calvin, *op.cit.*, pp. 688-724 - "The Sum of the Christian Life: The Denial of Ourselves" (Art III/VII - III/X).

(3) *Ibid.*, p. 708 (Art. III/VIII/IX).

within the Reformed tradition, constitutes a major ideological structure of the minister's world and may have some bearing on almost every facet of his life.

Representative and exemplary images of the ministry, together with the expectations associated with them, have had an obvious influence on the pattern of ministry conducted within the Church of Scotland. Normative standards have been established and are applied to the minister's physical habits, standards of hygiene, personality, temperament, pleasures and recreation, marriage and family life, and to his social relationships and activities. How far and in what ways individual ministers' personalities and personal lives are affected by these expectations is yet to be determined; but it cannot be doubted that they form a basic structure of the minister's world and set standards by which both his personal and vocational adequacy might be evaluated. These expectations appear to be founded on the dual assumptions that the minister, by his very calling, enjoys a special relationship with God and should therefore be a distinctive kind of person and that, furthermore, the minister's vocational responsibilities should take precedence over all other personal needs or responsibilities. These standards and expectations to which the minister is subject may conceivably have some influence on the individual's personal life and may have implications for the health of ministers.

CONCLUSION

The basic objective of this first phase of our inquiry has been to identify and describe the outstanding structures and characteristics of the Church of Scotland parish minister's world, particularly as it is exemplified by the experience of four active parish ministers. It cannot be assumed that the experience of only four men is normal or typical of all parish ministers; but, as far as possible, further

evidence has been elicited from a variety of relevant sources. Even though these four men provide an inadequate sample for representative purposes, it is notable that their experience is remarkably similar in many respects and a number of questions have been introduced which may prove to have relevance for the health of this group of clergymen.

Without reiterating the details of the preceding discussion, two central issues have come into prominence throughout this consideration of the minister's world from parochial, functional, and personal perspectives. In the first place, one wonders to what extent the conditions of the minister's life and work are the product of vocational requirements, congregational and parochial demands, religious-cultural expectations, or of intrapersonal motives and conflicts. It would seem probable that a complex constellation of factors are operative, in an intricate process of interaction. But, in the second place and of more immediate relevance, one wonders whether and in what ways the health of individual ministers is affected by the characteristic conditions of their vocation and occupation.

We will have cause to return to these fundamental questions at a later stage. For the moment, this broad panorama of the parochial, functional, and personal realms of the minister's world provides a background against which to give more particular consideration to specific aspects of the health experience of the Church of Scotland ministers. In the following phase, attention is directed toward the end results of being a Church of Scotland minister as this is revealed by mortality and morbidity data, which will provide an empirical foundation and point of reference.

PART III

HEALTH AND THE MINISTRY - STATISTICAL EVIDENCE

CHAPTER 8. HEALTH AND MANPOWER.

CHAPTER 9. MORTALITY EXPERIENCE.

CHAPTER 10. MORBIDITY EXPERIENCE.

CONCLUSION.

CHAPTER 8

HEALTH AND MANPOWER

INTRODUCTION

Death is the least equivocal indicator of a community's health.

The common causes and the age at which death occurs are "quite sensitive indicators of the state of health of the community under consideration" (J.M. Last, 1969).⁽¹⁾ Death is an absolute event which marks the conclusion of the individual life and may be recorded with a high degree of precision. Coming as the conclusion of life, death is the product of the variegated and intricate processes of human existence and the age at which it occurs and the causes of death may reflect the processes and experiences which precede it. Mortality data has the added value of providing a ready means of comparing the health of races, nations, cultural sub-groups, and occupational orders. However, mortality is purely symptomatic and interpretation is necessary in order to arrive at a diagnosis. Hence, morbidity data, concerning a community's experience of illness, disability, injury, and chronic diseases, provides additional and sometimes crucial diagnostic information. Morbidity data may cover aspects of a group's experience which are not necessarily disclosed by mortality data. Mortality and morbidity data combined provide a means of gaining substantial and reliable insight into the health experience of a community or group.

The second phase of this project comprises an investigation into the mortality and morbidity experience of Church of Scotland ministers from 1930 to 1969. Our attention will be devoted to the effects, in terms of illness and health, of being a Scottish parish minister during this period. Having established the salient features of the average parish

(1) J.M. Last; "Measurement of community health" (unpublished mss., 1969, courtesy of the author). Also compare with the view of F.A.E. Crew, *op.cit.*, p. 181 ff.

minister's life and work, the question then arises as to the kinds of effects these conditions have on the health of ministers in terms of illness, disablement, chronic diseases, causes and rate of death.

Moreover, having observed some of the major changes in the conditions of the ministry over a forty year period, one wonders whether these changes have been accompanied by or have even produced equally significant changes in the mortality and morbidity experience of these ministers.

It will be our purpose, in the first instance, to determine whether Church of Scotland ministers have enjoyed the favourable health record with which they have been popularly accredited; and, in the second place, we will aim to establish whether there has been any significant change in their experience, especially within the last decade.

Unfortunately, this task has been made unusually difficult due to important statistical problems which will become apparent as we proceed.

The experience of these ministers will be seen in perspective when considered against the background of Scottish experience and developments.

THE SCOTTISH PATTERN

All life experiences, with their intricate and interdependent relationship in the experience of the individual person, contribute to the phenomena of illness and death. Morbidity and mortality are the products of innate factors, like heredity, organic constitution, sex, and race. They are obviously relative to age, the durational factor, as the body's systems degenerate and its defences become less efficient and more prone to infection and accident. Then the environment, physical and social, in which a person or community exists makes a profound impact on health and its effects are eventually reflected in sickness and in the ultimate disintegration of death. Man has a dynamic, dialectic relationship with his total environment in which he responds and adjusts to its threats.

and challenges and in which he utilizes and remoulds the resources it affords. This relationship is never static and absolute, but is dynamic and changeable. So man shapes his environment and is in turn shaped by it in an endless process of interaction. Morbidity and mortality reflect this ceaseless struggle and may, at least partially, bear witness to a community's success or failure in controlling and adapting to the hazards and resources of its environment.

The Scottish experience of disease and death is typical of Western societies in most respects. Scottish demographic data indicates that some threats have been met and overcome. It is also evident, however, that in this process of challenge and response new health hazards have emerged, which is demonstrated by the Scottish pattern of mortality.⁽¹⁾

The Scottish death rate has been approximately halved over the last century, as is evident in the greatly increased life expectation of the Scottish population (Table 12: over). The life expectation of Scottish males at birth has been extended by almost twenty-seven years since 1841 and by thirty-one years for the female population in the same period. This is a notable advance.

Most of this increase was achieved in the thirty years between 1920 and 1950 in which the life expectation was extended by eleven and twelve years for men and women respectively. But in the last two decades the increase has been negligible with an addition of about two years to the Scottish life expectation.

(1) A brief survey of Scottish demographic data is provided by P.R. Cox, Demography (Cambridge Uni. Press, 1950), p. 278 ff. For further information concerning the Scottish Life Expectation 1941-1968 refer to

TABLE 12. SCOTTISH LIFE EXPECTATION AT BIRTH: 1841-1968

Year	Male	Female
1841	40.2	42.2
1861-70	40.3	43.9
1891-1900	44.7	47.4
1920-22	53.1	56.4
1930-32	56.0	59.5
1942-44	59.8	64.6
1950-52	64.4	68.7
1960	66.4	71.9
1965	66.5	72.6
1968	66.9	73.1

The extension of the life expectancy of the Scottish population has been brought about by a great reduction of deaths at birth and during infancy. Childbirth is no longer the dangerous ordeal that it once was and many of the hazards of infancy and childbirth have been controlled. This is particularly true of the major infectious diseases, such as smallpox, scarlet fever, dysentery, and meningitis, which contributed to high infant mortality and which have been eliminated or effectively controlled. With improved standards of living the chances of an infant dying from malnutrition and neglect have been significantly reduced. As a result, as in all economically developed countries, more than 95 per cent of those born survive until late adolescence and early adulthood.

However, although life expectancy has increased greatly at birth, at the age of forty five years it is not much greater than it was in 1900. For instance, in 1900 the Scottish male aged forty five years could expect to live a further 22.2 years whereas his counterpart in 1968 could expect a further 26.1 years, an increase of a little less than four years. At 65 years the Scottish male's life expectation has been extended by

about three years between 1900 and 1968. This means that the average life-span, by contrast with life expectation, has been prolonged only marginally since 1900 despite medical and technical advances, and some theorists doubt whether the average human life-span can be extended appreciably.⁽¹⁾

With progressive urbanization and industrialization, especially in the central belt of Scotland, and with the consequent depopulation of the Highland and Border areas, the differentiation between regional rates of death has become more marked. The urban death rates are predictably high, especially within the Glasgow conurbation. The regional rates of death then show an expected decline from urban areas and large burghs with dense populations and a high level of industrialization down to landward, rural areas with small, scattered populations. The seasonal death rate is expectedly highest in the first quarter (January/March) during the winter months and lowest in the third quarter (July/September) during late summer.

Changes in the principal causes of death have been particularly significant and the Scottish pattern reflects the experience of other Western countries. The most positive development has been the elimination or effective control of infectious diseases. Only influenza continues to be a significant cause of death, and its incidence is characterized by sporadic epidemics as in the "Spanish flu" epidemic following the First World War and the "Asian flu" epidemic in the early 1950s. Tuberculosis, which was a major cause of death up to the 1930s, has been dramatically reduced as a major cause of death since then.

This does not mean that disease has been conquered or that even infectious diseases have been completely eliminated. As Dubos and Pines

(1) For example, this conviction is expressed by R. Dubos (1960), *op. cit.*, p. 28, and by R. Dubos and M. Pines (1966), *op. cit.*, p. 9, 16.

comment: "Only the pattern of diseases changes with changing times and changing cultures".⁽¹⁾ Infectious diseases still hospitalize large numbers of people even though they are less likely to prove fatal.

Scottish experience further demonstrates the complex interaction between the human community and its environment. The technical, industrial, and socio-cultural developments of the post-war era have given rise to a new set of problems. The human community is involved in "a process of continuous adaptation to the myriad microbes, irritants, pressures and problems which daily challenge man" (Dubos and Pines, 1966),⁽²⁾ and it seems to be an inescapable characteristic of existence that as one threat is combated so another emerges. Heart disease, malignant neoplasms, vascular lesions affecting the Central Nervous System, violence, bronchitis and pneumonia have become the principal causes of death in Scotland. The proportion of deaths attributed to heart diseases, cancer, and various kinds of violence has increased alarmingly over a period of thirty years, as is typical of all highly developed countries, and each presents an urgent problem for medical research and community health. For instance, heart diseases were responsible for 18 per cent of male deaths in 1930-32 and by 1967 the proportion had risen to 34 per cent, or about one third of all deaths. The increasing prevalence of cancer as a cause of death has been no less dramatic, the crude rate increasing by 51 per cent between 1931 and 1967 and the standardised rate by 13 per cent. This development has been most marked in the male population with a crude increase of 77 per cent and a standardised increase of 45 per cent.⁽³⁾ These developments are

(1) R. Dubos and M. Pines, op.cit., p. 9.

(2) Ibid., p. 10.

(3) Annual Report of the Registrar General for Scotland, 1967 (H.M.S.O., 1968), p. 30.

characteristic of all industrialized, urban societies in varying degrees. Even so, in some respects Scotland's largest city, Glasgow, is one of the unhealthiest urban areas in the world with the ignominious record of having the second highest rate of death from heart diseases in the world and one of the highest rates of lung cancer and bronchitis in Europe.

Quite apart from their contribution to mortality, heart diseases, general atherosclerosis, cerebral thrombosis and embolism, violence, and bronchitis, together with arthritis, rheumatism, and, to a lesser extent, diabetes, also incapacitate and disable large numbers of people. Each of these afflictions has assumed growing importance in Scotland as elsewhere in the Western world. Professor Crew has described them as "the diseases of plenty" which "follow upon urbanisation, industrialisation, and rising standards of living".⁽¹⁾ They are, he suggests, typical of communities given to smoking, eating, and drinking excessively, exercising too little, mis-spending leisure, and to worrying too much about matters of little importance. It may be that these "afflictions of civilization"⁽²⁾ are also related to atmospheric pollution, high density population and industrialisation, congested traffic, and the stresses of living in such societies. Each presents a medical enigma requiring urgent attention.

So, although the Scottish life expectation at birth has been extended and the major infectious diseases have been controlled, the average life-span has not been significantly prolonged and a new set of chronic and fatal diseases have emerged which pose a continuing threat to the health of the Scottish population.

Everything else being equal, one would expect Scottish ministers to have a similar health experience to that of the male population and one would expect this to be demonstrated by their mortality and morbidity

(1) F.A.E. Crew, *op.cit.*, p. 49.

(2) R. Dubos and M. Pines (1961), *op.cit.*, p. 84.

experience. They are subject to the same socio-cultural-environmental conditions as their lay fellows and as a group their socio-economic backgrounds represent a broad cross-section of the community at large. However, another constellation of factors, those associated with occupation, intervene. We are here concerned with the effects of being a minister on the individual's health as this compares with the male population and with other professional groups, and we turn to mortality and morbidity data as a basis for that comparison.

Mortality and Morbidity Data

Death comes as the end result of the total process of human life and may provide a sensitive indicator of the health of a community or group. Although such information may present vital clues to the conditions of life and to the health hazards experienced by an occupational group, the limitations of this kind of material should be recognized.⁽¹⁾

As an absolute event, the fact of death and the age at which it occurs may be recorded with a high degree of precision. But mortality records are not necessarily accurate in every respect. Statements of the cause of death may be particularly unreliable. A death certificate does, after all, simply express a medical opinion and it is generally held that little over a half of all deaths can be accurately certified without autopsy examination.⁽²⁾ Allowance must therefore be made for observer error and bias, differences in terminology, and in the diagnostic resources available. It may be difficult to establish a single cause of

(1) These limitations are discussed in more detail by J.M. Last, *op.cit.*, P.R. Cox, *op.cit.*, p. 49 ff., and B. Benjamin, Elements of Vital Statistics (Allen and Unwin, 1959), p. 78 ff.

(2) J.M. Last, *op.cit.*, p. 240.

death in cases where intermediate or complementary causes have been involved or where other morbid conditions have been present prior to death.⁽¹⁾ Moreover, the difficulty in ascertaining a specific cause of death inevitably increases with age. However, the methods of recording mortality data and the diagnostic resources available in Scotland are probably as reliable as can be expected.

As the conclusion of a long and intricate process, death yields only limited information about the processes and experiences which precede it. The facts associated with death are only symptoms of the life-process leading up to it. These facts are therefore open to interpretation and different interpreters may arrive at inconsistent or variable conclusions.

Most importantly, mortality data alone is not an adequate index of health and considered in isolation it may be misleading. Many other important facts which may be indicative of health are not revealed by mortality data. For instance, it gives no indication of the frequency with which members of a community or group are incapacitated, temporarily or permanently, by hospitalization, chronic diseases, or disablement through illness, accidents or violence. Significant numbers of people may be rendered ineffective by chronic diseases and disorders, such as arthritis, cerebral haemorrhages, and coronary disease, by the physical damage caused by accidents and violence, and by long-term psychiatric disorders, such as organic psychoses, schizophrenia, and endogenous depression. As an ever increasing proportion of the population survives 70 years age these phenomena assume greater significance for social medicine and community health, but their impact on a group's health is not disclosed by mortality data.

(1) The Scottish death certificate in fact makes provision for the inclusion of complementary and subsidiary causes of death.

Morbidity data is, therefore, an additional and important guide to the health of any group. The pattern of illness experienced by a community has been frequently compared with an iceberg; and while a study of mortality establishes the obvious aspects of the iceberg which appears above the water-line, a study of morbidity, illness and disablement, may bring to light aspects hidden below the surface. It may be, with respect to occupational differentials, that morbidity proves to be even more significant than mortality. The report of the Manchester Unity in 1893 observed that ".....mortality seemed to vary chiefly with locality and density of population, but that sickness claims appeared to be influenced to a much greater extent by occupations".⁽¹⁾ However, morbidity data also has its limitations.

The initial problem is to establish criteria by which morbidity might be identified and measured. What constitutes a morbid condition? The dilemma is clearly stated by Percy Stocks in the standard reference on the measurement of morbidity:

"The distinction between living and dead is clear cut, but no such frontier between sickness and health can be said to exist except in the case of an acute illness caused immediately and directly by an external agent. There is a zone between the two states in which the division whether the subject is sick or not depends on definitions and standards of good health, and also on who decides."⁽²⁾

He suggests that a morbid departure from normal health may be identified as the point when either a person becomes conscious of symptoms or some disability or when someone else decides that disease is present.

(1) Quoted by P.R. Cox, op.cit., p. 189.

(2) Percy Stocks, "The measurement of morbidity", Royal Society of Medicine, Vol. 37, No. 10, 1949.

But, having established that a morbid condition is present, the investigator is then confronted with the problem of standardization for the purposes of comparison. Morbid states may range from a passing bout of influenza or a common cold to hemiplegia following a cerebral haemorrhage or the amputation of limbs subsequent to severe accidental damage. In the same article, Stocks suggests that morbidity could be classified by a four-point grading according to whether conditions were serious, moderate or mild, minor, or ill-defined.⁽¹⁾ Even such a gradation presents problems. For instance, some severe disabilities, such as amputations or partial paralysis, which would be completely incapacitating in some occupations would present no grave hindrance in others, because disability varies widely according to job requirements.

A further complication in attempting a comparative morbidity study is that the sources of information are limited and, to date, little has been done to collect, collate, and correlate comparative data. An investigation of the frequency and causes of hospital admissions could be fruitful and could provide a basis for comparing the occupational incidence of specific disabilities and disorders, but little work has been done in this area. At a national level, two studies have been conducted by government agencies which are useful aids to research. The first, undertaken by the Ministry of Labour and National Service (1959), was an investigation into the length of the working life of males in Great Britain.⁽²⁾ The tables presented in this report, based on the five years up to 1955, indicated the rate at which death and other causes could be expected to take men out of the national labour force. The "other causes" were not specified precisely but included

(1) P. Stocks (1949), op.cit.

(2) Ministry of Labour and National Service, The Length of Working Life of Males in Great Britain, 1955 (H.M.S.O., 1959).

illness, disease, injury, and retirement. The second was an inquiry into the incidence of incapacity for work in Britain, with occupational and regional variations, compiled by the Ministry of Pensions and National Insurance (1965).⁽¹⁾ These reports afford a useful basis for comparing occupational variations of morbidity. But, generally speaking, few detailed occupational morbidity studies are available.

While mortality and morbidity data are necessary for an investigation into the health of any group, such fragments of information have no intrinsic value. Material of this kind only establishes symptoms which are a means of building-up and of gaining insight into the pattern of the dynamic factors and processes which produce the symptoms. It is rather like fitting together the pieces of a puzzle which eventually produce a coherent picture. Any isolated, single piece makes little sense in itself and may be misleading. We are here concerned with the total field and field-processes experienced by Church of Scotland ministers in so far as these are reflected by their mortality and morbidity.

HEALTH AND MANPOWER

The Church of Scotland has had to contend with a continuing manpower crisis ever since the last World War with a progressive shortage of men available for the ministry.⁽²⁾ The number of men actively engaged in the ministry was 626 fewer in 1968 than it had been just prior to the War in 1939; in the 1950-60 decade, 1,000 men were admitted to the ministry.

(1) Ministry of Pensions and National Insurance, Report on an Inquiry into the Incidence of Incapacity for Work, Part II: The Incapacity for Work in Different Areas and Occupations, 1965 (H.M.S.O., 1967).

(2) q.v. Part II: Chapter 5. Also see Appendix II: Table 2A.

shortage of men has been felt most acutely in the parish ministry, and the Church of Scotland administrative bodies have had increasing difficulty in staffing and maintaining the parochial system and in achieving an equitable distribution of manpower. It seems to be an appropriate starting-point to consider whether illness, disablement, and death have made any contribution to this persistent problem.

The manpower shortage has been reviewed in detail at an earlier point, and no further elaboration is required. The progressive shortage of candidates, especially since 1952, is beyond dispute. What is both curious and relevant at this point is that in the published reports of the Church's administrative committees the problem has been considered exclusively as one of recruitment, and as was seen earlier a variety of reasons have been put forward to explain this phenomenon. Recruitment has been presented as being the crucial issue, and there is no doubt that this has been a major cause of concern for the Church of Scotland since the early 1940s. But what of the other end of the process: the loss of men by resignation, illness and disablement, retirement, and death? Have ill-health and death made any contribution to the Church of Scotland's manpower crisis?

An examination of all the reports to the General Assembly would suggest that this possibility has never been seriously considered. The only reference to the consequences of a possible wastage of manpower through illness, age, and death appeared in the 1964 report of the Education for the Ministry Committee in which it was predicted that, with the average age of ministers in excess of 50 years and rising, one half of the existing manpower would be lost through retirement or death by 1980 or soon afterwards.⁽¹⁾ In this event there would be a critical shortage which would become even more acute if the age of

(1) Reports to the G.A., 1964, p. 514 ff.

retiral were lowered. In fact, this was carried out by the 1968 General Assembly when the official retiral age was lowered from 70 years to 65 years,⁽¹⁾ and it remains to be seen how many ministers take advantage of this opportunity.⁽²⁾

It is a striking fact that not one report has investigated the manpower problem from this end, that is, in terms of wastage. Not one report has attempted an analysis of the losses from the ranks of the ministry, the rate or extent of such losses, or the causes of such losses. These questions do not seem to have been asked. If they have, then they have certainly not been expressed officially.

While not disputing the actual decline in candidates and the importance of this fact, the apparent failure to consider ill-health as a possible contributor to the growing shortage seems to be a strange omission, especially when there appears to be good reason for at least suspecting that it may have further exacerbated the problem. This oversight is even more surprising when one recalls the results of actuarial investigations reported to the General Assembly in 1957, 1958, and 1963.⁽³⁾ These reports confronted the Assembly with a disturbing development: between 1952 and 1962 there had been a substantial increase in deaths among contributors and pensioners in the Church's pension fund in the 65-74 age group, that is, in the five years both preceding and following the official retiral age of 70 years. Deaths in the 70-74 age group were 80 per cent and in the 65-69 age group were 40 per cent

(1) Reports to the G.A., 1968, p. 235.

(2) It became possible for a minister to retire on a full annuity at the age of 65 provided he had served a minimum of forty years in 1966. In the following year it was reported to the General Assembly that five men had retired under these new regulations (Reports to the G.A., 1967, p. 361).

(3) q.v. Part I: Chapter 2.

in excess of normal. The latter group are of particular note in this context because it means that men were being lost to the active ministry at an increasing rate before attaining retiral age. It would seem that this fact was either overlooked by or escaped the attention of those concerned with the manpower problem.

THE LOSS OF MANPOWER

There are a variety of ways by which men may be lost from the ministry in general and from the parish ministry in particular: including movement to non-parochial positions, leave of absence for varying periods, resignation, early disablement, retirement, and death. But it is difficult to ascertain the extent to which ill-health is involved in the temporary or permanent loss of men from the ministry, except in the most obvious cases such as the death of men before reaching retiral age or cases in which men retire early due to infirmity. For instance, the Church's official records do not specify whether individual cases of retirement or resignation are due to age, infirmity, an intent to enter secular employment or to transfer to another denomination, or to any other personal cause. There are, for this reason, many unknown quantities in the loss of men from the ministry. The mobility of Church of Scotland ministers, between parishes, between the ministry and secular employment, between the parish ministry and non-parochial specializations, presents a further complication in determining the effects of illness and disability on the manpower of the Church of Scotland. But it seems likely that their contribution to the crisis is more substantial than appears on the surface.

(i) Non-parochial ministries. Fears have been expressed that the territorial principle and the parish system, which is fundamental to the Church's strategy, have been placed in jeopardy as more men are

drawn from the ranks of the parochial ministry to meet the growing needs of so-called 'specialist ministries' and as an increasing number of students have a declared intent to engage in non-parochial ministries if the option is open to them. Transfers from the parochial ministry to non-parochial ministries are inevitable because, with few exceptions (viz. Professors, Chaplains to the Deaf and Dumb, and Overseas Missionaries), ordination is limited to those being inducted into a "pastoral charge" in a parish. In any event, these fears have been exaggerated and have no foundation in fact.

There has not been a massive movement of men opting for specialized spheres of ministry, although many may have expressed the desire to do so. In 1939 the proportion of ordained ministers engaged in non-parochial ministries, including Chaplains to the Armed Services, administrative and academic positions, overseas missionaries, colonial and continental charges, and specialized ministries to hospitals, the deaf and dumb, universities and other educational institutions, was 10.8 per cent. In 1968 the proportion was 12.0 per cent, an increase of little more than one per cent which is hardly excessive. The balance has been maintained because some specialist ministries, such as Chaplains to the Armed Services (209 in 1945 to 32 in 1968), have required fewer men while others, such as academic positions and various specialist chaplaincies, have been expanded. So the impression of a substantial withdrawal from the parish ministry into these other fields of ministry is largely illusory. In recent years an average of thirteen men per year have been required for such positions.⁽¹⁾

(1) Reports to the G.A., 1964, p. 514 ff. In 1965 it was further reported that there were 148 ordained ministers in extra-parochial positions. In the previous twelve months 16 had moved into such positions, and the total for the preceding five years (1960-1964) had been 64 (Reports to the G.A., 1965, p. 682).

Of more importance in this context are the motives of this group of men in preferring non-parochial forms of ministry. More explicitly, do personal difficulties, emotional stress, or ill-health experienced in the parish ministry have any bearing on the decision of men to become full-time administrators or university chaplains or academics? There are probably diverse motives for taking such a step: a sense of vocation for a particular field of service, the attractiveness of the position, the desire to utilize specialized training and skills, possibly a wish to escape from stresses and conflicts experienced in the ministry, and many others. However, how far the ill-health factor, especially in the form of personal conflicts and emotional stresses, contributes to such decisions is purely a matter of speculation.

(ii) Leave of Absence. The number of men temporarily lost to the active ministry through leave of absence for varying periods cannot be precisely determined without an extensive survey. In the petition for the introduction of Sabbatical Leave to the 1969 General Assembly⁽¹⁾ figures from six Presbyteries were quoted. In a city Presbytery six per cent of its parish ministers had required "extended leave of absence" over a period of three years; in a town and country Presbytery the proportion had been 20 per cent over the same period; and in a rural Presbytery the proportion had been 26 per cent over a five year period; and in the other three Presbyteries the figures ranged from 3-20 per cent. In the case of the rural Presbytery, it was noted, all those seeking leave of absence were under 55 years of age. Unfortunately no details were given of the reasons for such leave of absence although it was implied, in presenting the petition, that a large number of the cases were due to illness, "nervous breakdowns", and the effects of prolonged mental and emotional stress in the parish ministry.

(1) q.v. Chapter.2.

The extent to which men are temporarily lost for varying periods of leave of absence cannot be established with any certainty. Moreover, it must be recognized that ill-health is only one of a number of reasons for seeking leave of absence and it should not be automatically assumed that a minister has gone on leave for "health reasons".

(iii) Unattached, Ministers Without Charge. The Church of Scotland has a group of men who are officially listed as being Unattached. They are men who hold no position within the Church of Scotland but who retain their status as Ordained Ministers and who could resume a pastoral charge within the Church if they wished to do so at any time. The number of men in this category has risen appreciably: they numbered 109 in 1946 and increased to 155 in 1968. This represents a rise from approximately four per cent to seven per cent of the total ordained manpower available to the Church of Scotland.

Again, there are many reasons for becoming "unattached". Some of these men are employed in secular occupations; some are engaged in positions related to the work of the Church but which are outwith the jurisdiction of the Church of Scotland, for instance, in the British or World Council of Churches, the World Presbyterian Alliance, religious publication bodies, and other Christian organizations: some hold academic posts in universities, theological colleges, and teacher-training colleges; and yet others are referred to as "sticket", those who have been unable to secure a pastoral charge within Scotland. However, this is a growing and remarkably varied group.

It is almost certain that this category includes men who have demitted their charges, at least temporarily, for health reasons in order to obtain intensive treatment and to recuperate from their physical or mental ailments. It is known that this occurs, sometimes

voluntarily and in other cases by persuasion. In such cases the minister's condition is unlikely to be permanently incapacitating and does not warrant retirement given appropriate treatment. But the frequency of and reasons for such an occurrence are unknown quantities; nor can it be determined whether ill-health has contributed to the growing number of men in the "unattached" category. This would have to be the subject of a specific inquiry.

(iv) Resigned, Left the Service of the Church of Scotland. Men who resign from the ministry could be a most important group in studying the health of clergymen, but it is almost a hopeless task to obtain adequate information on this group without undertaking a special investigation. In the Church's annual records all ministers who have retired or resigned are grouped together and no differentiation is made between those who retire due to age, those who retire due to infirmity, those who resign voluntarily, or those who are deposed. It is a major and well-nigh impossible task to establish the number of men in each of these categories in any year, and this is probably necessitated by the need to maintain confidentiality. Nevertheless, a number of men do resign from the Church of Scotland ministry each year and, although it cannot be supported by precise figures, the proportion has been increasing.⁽¹⁾

There are many possible reasons for resignation from the ministry. Some resign to enter the ministry of another Presbyterian Church or of another denomination, and the number of men emigrating to serve other Presbyterian Churches has risen appreciably from 56 in 1939 to 154 in 1959.⁽²⁾

- (1) In private correspondence with the author, Rev. Karl Greenlaw, Secretary of the Church and Ministry Department, has stated that more men have been resigning from the ministry in recent years.
- (2) The most recent figure available was provided in the Church of Scotland Year Book 1962 when 120 ordained ministers were engaged in the service of other Presbyterian Churches. This list has since been deleted from the Annual Year Book.

Some resign because they consider that they could make better use of their skills and make a more worthwhile contribution in secular employment. Some express feelings of dissatisfaction and frustration with the anachronistic aspects of the Church's life and decide that they could serve a more useful purpose in another sphere. In some cases men doubt the validity of their religious vocation or Christian conviction. None of these and many other possible reasons for resignation are necessarily related to ill-health. It should not be assumed, as some ministers are apt to do, that a clergyman who seriously doubts his vocation or faith and subsequently resigns is necessarily sick or disturbed in some way. However, it is certain that the withdrawal of some men from the ministry is more or less directly influenced by illness, emotional disturbances, and personal crises.

But, once again, the number who resign for "health reasons" is another unknown quantity. There are reasons for thinking that this group could be of considerable importance in studying the health of clergymen, but it is difficult to obtain reliable and adequate information. It is probable that some ministers resign on medical advice or on their own initiative in order to take up an occupation which involves less nervous strain and emotional tension. Resignation may be precipitated by a personal crisis or a breakdown in health. It also appears to be an inescapable fact that ministers are sometimes forced to resign by subtle and intensive pressures exerted on them by their Kirk Sessions or congregational members. This may occur in cases where a congregation is offended by or objects to its minister's aberrant behaviour, eccentric personality, poor personal relationships or any other inadequacy, or even his unorthodox ideas. If more devious means, such as social ostracism,

a boycott on services of worship, persistent opposition and apathy, do not succeed then the threat of disciplinary action, public exposure, and disrepute may achieve the desired result. There is no doubt that men are sometimes pressurized into resignation but how frequently this happens is virtually impossible to determine. In some other cases, a minister who proves to be an embarrassment may be directly, although unofficially, advised to resign by senior colleagues and officials. Such transactions are strictly off the record but are a means of avoiding disciplinary action and are probably initiated with the best of intentions. Whether the outcome is positive and helpful for the individual concerned is dubious; at least the embarrassment and threat of scandal is removed. If unofficial means do not succeed then the only course of action left open is to instigate disciplinary procedure which could lead to the minister being deposed. No figures are available on the number of ministers deposed as a result of extreme personality or behavioural problems, but by all accounts it has become rare in the post-war era.

Incidents of this kind should not be exaggerated. As in any human group, one would expect abnormalities such as alcoholism, drug addiction, homosexuality, promiscuity, or severe psychiatric disorders, and acute personal crises to occur within the ministry. This should come as no surprise and certainly does not justify the newspaper headlines which such incidents inspire in Scotland.⁽¹⁾ But for our purposes both sides of the problem, on one hand, the nature of the complaints and difficulties suffered by these ministers, and on the other, the Church's manner of dealing with such circumstances, are relevant. Except in the few cases which become matters of public knowledge, the disorders which precipitate such resignations are concealed. One effect of this is that the incidence of psychiatric, personality and behavioural disorders among Church of

(1) q.v. Chapter 7.

Scotland ministers is almost certainly deflated, possibly creating an illusion of unusually sound mental health in this group. Moreover, the therapeutic consequences of such unofficial procedures should be considered and once again raises the question of the adequacy of existing measures for the pastoral care of ministers within the Church of Scotland. No doubt there are instances in which men, whose personal difficulties have gone undetected, have resigned spontaneously without any direct or indirect pressure on them. The very fact that this could happen perhaps provides another commentary on the efficacy of the pastoral care of ministers.

The point which emerges from this discussion is that there are a number of ways in which men are lost to the active ministry, either temporarily or permanently, to which illness and personal difficulties probably are important contributory factors. But the extent to which illness is the precipitating factor in men seeking leave of absence, becoming unattached, or resigning from the ministry is an unknown quantity. The whole issue appears to be effectively concealed in a collusion of silence and it is virtually impossible to get beyond the level of hearsay, which inevitably restricts any investigation of the health of Church of Scotland ministers. An intensive investigation of this "unknown quantity" would probably be worthwhile in itself and could provide vital information on the health of these clergymen, especially as it possibly involves some of those men most in need of care and treatment.⁽¹⁾

- (1) A small-scale inquiry of this kind was conducted in the United States by E.W. Mills, "The Minister's decision to leave the parish" (unpublished paper, 1965). This was based on a survey of 60 Presbyterian ministers who had left a parish to enter secular employment, to engage in graduate study, to transfer to another parish, or to take up an executive post. The main motives for taking up secular work were serious personal conflicts, marital crises, and a sense of helplessness in the parish; men resumed graduate study because of previous plans to do so or because of

(v) Retirement Due to Infirmary. Another source of the wastage of manpower, in which illness is directly involved, are those circumstances in which ministers retire due to infirmity or early disablement before attaining retiral age. The Church of Scotland's Aged and Infirm Ministers' Fund makes special provision for the retirement of ministers incapacitated by infirmity, disease, and disablement. This is an important category and information has been made available on the frequency and causes of early disablement between 1950 and 1968. In this period 217 ministers, or an annual rate of approximately 12, were enabled to officially retire because of their incapacity for work and these cases receive special attention at a later stage.⁽¹⁾

(vi) Early Death. It is inevitable that death should take some men from the ministry before they have completed their full-term, that is, before completing forty years in the ministry. It is self-evident that illness and disease are involved in these circumstances and it is possible to calculate the losses due to early death over the period under study. In view of recent claims, one wonders whether these losses have increased in recent years and whether this has aggravated the manpower problem. This cannot be determined without closer examination of the mortality experience of Church of Scotland ministers, which is the purpose of the following chapter.⁽²⁾

As a preliminary step in determining the affect of illness and death on the ministerial resources of the Church of Scotland it is possible to make three relatively simple calculations. The first is to compare the

serious conflicts in the Church; the attractiveness of the position drew men into executive appointments; and they moved to new parishes because they were restless for a new challenge.

(1) Chapter 10: Morbidity Experience: following.

(2) Chapter 9: Mortality Experience: following.

annual rate of recruitment into the ministry with the rate of loss through resignation, retirement, and death. Secondly, it is possible to calculate the extent to which men ordained and admitted to the ministry in a specific period have been lost through illness and death. Then, thirdly, the total loss due to mortality and morbidity over a given period may be estimated.

(1) Annual Intake and Wastage Rates

Each year the Church of Scotland loses a number of men from the active ministry through resignations, retirement, and early deaths, and these losses have to be met by men being ordained and admitted to the ministry. But there has always been a gap, ever since the 1930s, between the annual intake and losses. The leeway has never been made up and, in consequence, the total population of Church of Scotland ministers has steadily declined.

As noted earlier, progressively fewer men have been entering the ministry, declining from an intake of 906 in 1930-1939 down to 652 in 1960-69 (See Table 5, q.v.). This is a problem in itself. At the same time, the total number of deaths has fallen with an ever-decreasing population, and only a detailed mortality study can reveal whether these decreases have been correlative. By contrast, however, losses through retirement and resignation increased from 635 in 1930-39 up to 812 in 1950-59, despite the smaller total population, and then fell again to 629 in 1960-1969 (Table 5). This fluctuation, with a marked increase during the 1950s, is possibly due to a number of factors: the rising average age of ministers and provisions for earlier retirement with a consequent increase in retirals, together with an increasing rate of resignations.

Closer examination of the rate of intake by ordination and admission compared with annual losses through resignation, retirement,

and deaths under 70 years of age indicates that the gap has been narrowed. In the period 1930-32 the average annual intake of ministers, 79 per year, fell short of making up the annual losses by an average of 34.

1930-1932	Retirements/Resignations:	77 per annum
	Deaths under 70 years:	<u>36</u>
	Average annual loss from active ministry:	113 per annum
	Ordained/Admitted:	79 per annum
	Average Annual Shortage:	<u>34</u>

During the period 1950-1959 the average annual shortage was slightly higher, being 36 on average, which is considerably higher as a proportion of the total population. It was during this period that the manpower problem was most critical. But for the period 1960-69 the disparity between the rate of intake and the rate of losses has been significantly reduced. In this last decade the average annual shortage has been as low as 18.

	1950-1959	1960-1969
Retirements/Resignations:	81 p.a.	63 p.a.
Deaths under 70 years:	28	20
	<u> </u>	<u> </u>
Average annual loss from active ministry:	109	83
Ordained/Admitted:	73	65
	<u> </u>	<u> </u>
Average Annual Shortage:	<u>36</u>	<u>18</u>

These figures, however, are deceptive. Certainly the disparity between the annual intake and losses has been reduced in terms of total numbers in the last decade. But the shortage has persisted, with the effect of steadily reducing the total ministerial manpower of the Church

of Scotland which has allowed little latitude for the development of Church extension schemes or for the instigation of many more non-parochial ministries. In fact, the Church of Scotland has only been able to maintain a reasonable distribution of manpower by reducing the total number of parishes by 961, from 2,898 in 1930 to 1,919 in 1969.

More importantly, these figures conceal the fact that the average rate of loss from the active ministry by resignation, retirement, and early death has remained relatively constant in relation to the total population. The average annual rate of wastage from these causes has varied only marginally between 3.5 and 4.5 per cent of the total manpower; which means, in other words, that three to five men in every hundred are lost to the active ministry each year. These losses include those who resign for health reasons, those who retire due to early disablement and infirmity, and those who die before reaching retiral age, and in very general terms it would seem that the rate of wastage from these causes has remained relatively constant.

(2) Experience of men ordained or admitted 1930-1939

An examination of the experience of men ordained or admitted to the ministry of the Church of Scotland between 1930-1939 gives a clearer indication of the effects of illness and death on the Church's manpower over a period of time. This generation is chosen for closer scrutiny because most of these men could be expected to be in the last ten years of their active ministries. A man aged 30 at ordination in 1930 would be 69 years of age in 1969 and approaching the usual retiral age, and a man aged 30 at ordination in 1939 would be 60 years of age in 1969 and would be entering the last few years of his active ministry. The majority of men ordained during that period, 86 per cent, were aged between 27 and 32 years at ordination so that their ages ranged from approximately 58 - 72 years at December 1968. By examining their

experience it is possible to estimate the extent to which illness and death contributes to the loss of manpower over a period of time.

The number of these men lost to the active ministry for any cause, death, early disablement, retirement, resignation, transference to another denomination, or unattachment, has been calculated as at December 31st, 1968, and the figures are tabulated in Tables and following. They have been separated into two quinquennial periods, 1930-1934 and 1935-1939, which roughly represent the age groups 65-69 and 60-64 respectively. The three columns which are of particular interest are those which list the losses from deaths under 70 years of age, from retirement due to infirmity but who died in excess of 70 years, and from retirement due to infirmity or early disablement but who were surviving at December 1968. The wastage of men from these causes may be directly attributed to illness and infirmity.

The figures presented here give a clear indication of the affect of illness and death on the ministerial resources of the Church of Scotland. For the first quinquennium under review, 1930-1934 (Table 13), the overall loss of men from the active ministry has been 63 per cent which has occurred over a period of 34-38 years and many of the survivors can be expected to retire over the next five years. Of the total wastage, almost 33 per cent or one third of the total manpower has been lost through causes directly related to illness. The greatest single cause for these losses has been early death under the age of 70 years, which has affected 27 per cent of those ordained in these years. These figures are slightly inflated by those who were war casualties, who totalled 8, and when allowance is made for these the loss due to illness and death is 30.8 per cent and the loss due exclusively to early deaths is 25 per cent.

TABLE 13: EXPERIENCE OF MINISTERS ORDAINED OR ADMITTED
1930 - 1934 (as at December 31st, 1968)

Year	1930	1931	1932	1933	1934	Totals
Total Ordained/Admitted	73	82	89	102	97	441
Total Active in Church of Scotland Ministry, Dec. 1968	20	33	48	24	40	161
1. Total Deceased (War Casualties)	23	23 (2)	26 (1)	53 (4)	31 (1)	156 (8)
2. *Deceased under 70 years age	18	14	21	39	27	119
3. *Retired Infirm: deceased 70 years and over	-	1	-	3	2	6
4. *Retired Infirm	6	4	3	3	3	19
5. Retired Age	5	3	3	1	3	15
6. Serving other Presbyterian Churches	5	4	4	9	12	34
7. Resigned - left service	3	2	1	2	4	12
8. Unattached	-	2	3	3	1	9
9. Unknown	1	1	1	-	2	5
TOTAL LOSSES	53	49	41	71	58	278
Percentage Loss	72.6%	59.6%	46.0%	69.6%	59.7%	63.0%
LOSSES DUE TO ILLNESS AND DEATH	24	19	24	45	32	144
% Loss due to Illness and death	32.8%	23.1%	26.9%	44.1%	32.9%	32.6%

(Note: Losses due to illness and death calculated from
columns 2, 3, and 4)

At first glance, the loss of 30 per cent of the available manpower due to illness and death before retirement age appears to be unusually high. It is seen in perspective when compared with the experience of British males in general. In 1955 the Ministry of Labour and National Service presented tables on the expected working life of British males and, based on the experience of 1952-1954, calculated the expected rate of losses from the work-force at every age due to death and other causes.⁽¹⁾ According to these figures, the probability that a man aged 30 would have withdrawn from the work-force by the age of 65 was 37.6 per cent. The probability that he would be lost through death was 27.8 per cent and that he would withdraw for other reasons, such as disablement, emigration, or retiral, was 9.9 per cent. It is difficult to make an exact comparison, but the actual experience of Church of Scotland ministers appears to approximate these probabilities. Nevertheless, the loss of at least 30 per cent of the Church's ministers by death or disablement before the age of retirement constitutes a significant number of men to be replaced. It should be remembered, moreover, that this is a minimal figure and would certainly be higher if the number of men who have resigned or become unattached or even emigrated for health reasons could be established.

The experience of ministers ordained and admitted in individual years during this quinquennium presents some inexplicable anomalies. As one would expect, the highest proportion of losses has been experienced by men ordained in 1930, who represent the oldest age group, with an overall loss of almost 73 per cent and with a 30 per cent loss due to illness and death. By comparison, men ordained and admitted in 1933 and 1934 have had a most unfortunate experience. This is most marked

(1) Ministry of Labour and National Service (1959), op.cit.

TABLE 14: EXPERIENCE OF MINISTERS ORDAINED OR ADMITTED
1935 - 1939 (as at December 31st, 1968)

Year	1935	1936	1937	1938	1939	Totals
Total Ordained/Admitted	104	79	111	107	112	516
Total Active in Church of Scotland Ministry, Dec. 1968	47	38	61	62	65	273
1. Total Deceased (War Casualties)	28 (1)	22 (3)	23 (4)	17 (2)	27 (1)	117 (11)
2.*Deceased under 70 years age	21	16	19	13	21	90
3.*Retired Infirm: deceased 70 years and over	1	2	1	-	1	5
4.*Retired Infirm	4	-	4	1	3	12
5. Retired Age	7	3	8	11	3	32
6. Serving other Presbyterian Churches	14	7	9	8	3	41
7. Resigned - Left Service	2	3	1	2	3	11
8. Unattached	4	3	5	6	6	24
9. Unknown	1	3	-	-	2	6
TOTAL LOSSES	60	41	50	45	47	243
Percentage Loss	56.1%	51.8%	45.1%	42.1%	41.9%	47.8%
LOSSES DUE TO ILLNESS AND DEATH	26	18	24	14	25	107
% Loss due to Illness and Death	25.0%	22.8%	21.6%	13.1%	22.3%	20.7%

with the group admitted to the ministry in 1933. Of 102 admissions in that year only 24 were still active in the ministry of the Church of Scotland at December 31st, 1968, representing a total loss of 70 per cent - almost as high as the 1930 group. Even more surprisingly, losses from the 1933 group due to illness and death has been 44 per cent - more than 10 per cent higher than the 1930 group and more than 20 per cent higher than the 1931 group. This is a curious phenomenon, for which there is no obvious explanation.

For the following quinquennium, 1935-1939 (Table 14), involving a younger age group the overall losses have been lighter, as would be expected. For the entire period the proportion of men lost from the ministry due to all causes has been 48 per cent, that is, 15 per cent lighter than for the preceding five years. Once again, the majority of those lost have been victims of early death which has been responsible for the loss of 15 per cent, excluding those who were war casualties. The total loss due to illness and death, again allowing for war casualties, has been 19 per cent which is about 10 per cent below the previous period. An unusual feature of these figures appears in the experience of the group of men ordained and admitted in 1938, which is in sharp contrast to those ordained in 1933. The overall loss of these men, 42 per cent, is consistent with the rate of loss for the whole period, but an unusually small proportion of these men have been lost to the ministry in consequence of illness or death by comparison with those ordained in 1937 and 1939. There is no ready explanation for this fact.

The experience of these men ordained and admitted in the pre-war decade does not establish whether such losses have been occurring at an increasing rate, but it does give a general indication of the rate at which and the extent to which men are taken from the active ministry by

disablement, illness, and death, before they have completed a full-term of service. . . . Allowing for the war casualties suffered by this particular generation, these figures suggest that the Church of Scotland could expect to lose in the vicinity of 20 per cent of its manpower over a period of 30-34 years rising to about 30 per cent over 35-40 years exclusively as a result of disability, disease, and death. It must be remembered, furthermore, that these losses would be greater if the number resigning, becoming unattached, or emigrating for undisclosed health reasons could be established.

(3) Experience of ministers ordained and admitted, 1946-1955

Some provisional figures on the experience of ministers admitted to the ministry in the immediate post-war decade, 1946-1955, can be offered (Table 15) and some interesting details emerge. During this period 872

TABLE 15: EXPERIENCE OF MINISTERS ORDAINED AND ADMITTED,
1946 - 1955*

	1946-1950	1951-1955	Totals
Total Ordained/Admitted	504	368	872
Total Deceased	18	12	30
Deceased under 70 years	18	11	29
Retired Infirm, but survived 70 years	-	1	1
Retired Infirm: Survivors	5	5	10
Retired Age or Resigned	9	12	21
Unattached	19	26	45
Total Losses	51	55	106
Percentage	10.1%	14.9%	12.1%
Losses due to illness and death	23	17	40
Percentage	4.5%	4.6%	4.5%

(* Calculated as at December 31st, 1968.)

men were ordained and admitted to the ministry. The rate of intake was most satisfactory in the first post-war quinquennium, thanks to the introduction of the special course of training for War-Service Candidates, with 504 admissions. This compares favourably with the pre-war intake rate. However, there was a marked drop in the number of men offering for the ministry in the next five years, with only 368 admissions to the ministry.

By December 1968, at least 106 or 12 per cent of these men had been lost to the active ministry (the number would be greater if it were possible to determine how many have withdrawn to serve other Presbyterian churches). But it is curious to note that a higher proportion has been lost from the second of these two quinquennial periods, 1951-1955, that is, from the group of men who now fall into the 40-45 age group and who have been ordained for periods from thirteen to seventeen years. Not only were fewer men ordained during this period but the Church has subsequently lost the service of proportionately more of them. Losses due to illness and death partially account for this fact. The proportion of men who have been the victims of illness, disability, and death, has been the same for both periods, 1946-1950 and 1951-1955, even though the latter group represents a younger age group. It is equally significant that a much larger proportion of those admitted in the later period have become unattached or have resigned from the ministry. This reflects the increasing rate of both unattachment and resignation, which has undoubtedly contributed to the manpower crisis in recent years. Only a detailed survey would ascertain whether illness has played a significant part in this development.

Apart from these inexplicable anomalies, the Church of Scotland has lost 4.5 per cent of the men ordained and admitted from 1946 to 1955

directly in consequence of illness and death. This has occurred over a period from thirteen to twenty two years.

(4) Effects of mortality and morbidity, 1950-1968

Another general estimate of the effects of illness and death on the ministerial resources of the Church may be gained by estimating their effect on a population at risk over a given period of time. What proportion of all the active ministers at risk since January 1st, 1950, had become the victims of illness and death by December 31st, 1968? The following table (Table 16) is based on the assumption that a man's ministry is usually expected to end at the age of 70 years, although it has become possible to retire at 65 years and although some men frequently continue in the ministry beyond 70 years. Therefore, the losses recorded are those attributable to retirement due to disability and to death under 70 years of age. At December 31st, 1949, there were 2,721 men actively engaged in the ministry and a further 1,232 have been ordained and admitted since then, giving a total population at risk of 3,953.

TABLE 16: EFFECTS OF DISABLEMENT AND DEATH, 1950-1968

Total Active in the Ministry at Dec. 31st, 1949	2,721
Ordained and Admitted 1950-1968	1,232
Total population at risk	<u>3,953</u>
Losses due to illness/death, 1950-1968:	
Total retired due to infirmity and early disablement	217
Total deceased under 70 years age (excluding those retired infirm)	390
Total loss due to morbidity and mortality	<u>607</u>
	= 15.3%

Over a period of nineteen years, at least 15.3 per cent of the total population at risk has been lost directly as a result of infirmity and death. If anything, this is an under-estimate and the total wastage due to mortality and morbidity is certainly higher. The population at risk would be appreciably smaller if allowance was made for those who were active at the beginning of the period but who already exceeded 70 years of age.⁽¹⁾ It would be reduced even more if those who have subsequently resigned from the ministry, and who are no longer strictly-speaking at risk, were excluded. If either of these things were done it would have the effect of increasing the proportion of active ministers affected by infirmity and death during this period. Moreover, the total loss would be greater if all those who have left the active ministry for other unspecified health reasons could be established.

CONCLUSION

We have seen that the Church of Scotland has been faced with a manpower crisis, with a steadily decreasing number of men available for the active ministry. The main reason for this shortage has been the diminishing number of candidates for the ministry, especially since 1950-52, and the problems of recruitment have received a great deal of attention from the Kirk's administrative bodies. But we have also noted that the same attention has not been given to the other end of the problem and the possible significance of losses due to illness, disability, and death seems to have been overlooked despite the unfavourable actuarial reports presented to the General Assembly in 1957-58.

(1) According to the 1951 Census 159 ministers of the Church of Scotland aged 70 years or more were still actively engaged in the ministry: 75 of these were 75 years or more.

The main problem in determining whether ill-health has had an appreciable effect on the ministerial resources of the Church is the presence of a number of unknown quantities. It is not possible to determine the extent to which ill-health is responsible for men seeking extended leave of absence, for becoming unattached, or for resigning from the ministry, without undertaking a survey specifically designed for this purpose. Such a survey could provide vital information on the health of ministers, particularly as there is reason to suspect that these categories include some of the men most in need of care and treatment for their complaints. It may be that these unknown quantities and the secrecy which surrounds them has the effect of deflating the incidence of psychiatric, personality, and behavioural disorders among Church of Scotland ministers; but that is open to conjecture.

The figures which we have reviewed here are concerned primarily with those men who have been lost to the active service of the Church due either to their early disablement necessitating retirement or to early death before they have attained the age of 70 years. These figures do not establish whether ill-health has exacerbated the manpower crisis to any extent. It is not clear whether such losses have been occurring at an increasing rate, but some interesting facts have emerged from these crude figures.

(i) In terms of total numbers, the gap between the annual intake and the annual loss of ministers due to retirement, resignation, and death has persisted, on the debit side, but has been narrowed. The average annual shortage was 36 in 1950-59 and decreased to 18 in 1960-69. But this conceals the fact that the annual rate of such losses in relation to the total population has remained reasonably constant, varying between 3.5 and 4.5 per cent of the Church's total active manpower in any year. In other words, the Church could expect to have to replace from 3 to 5 men in every 100 each year directly as a result of illness and death.

(ii) On the basis of the experience of men ordained or admitted to the ministry between 1930-1939, the Church could expect to lose at least 20 per cent of its manpower over a period of 30-34 years and 30 per cent over 35-40 years as a direct result of disability, illness, and death. At this rate, a third of those ordained and admitted to the ministry would not complete a full-term of forty years service because they have been incapacitated or have died; and this is certainly an underestimate of the total losses from ill-health. It has also been seen that, for no apparent reason, the group of men ordained in 1933 have had a particularly unfavourable experience. Within 35 years 70 per cent, or 2 in every 3, were no longer actively engaged in the ministry and 44 per cent or almost one half had been lost due to illness, disability, and death. The majority of these had died under 70 years of age.

(iii) Of those ordained and admitted to the ministry in the post-war decade, 1946-1955, 4.5 per cent had been lost to the ministry by the end of 1968 as a result of illness and death. Those admitted in the second half of the period, 1951-1955, have a worse record than their predecessors even though they represent a younger age group. Although their average age is lower, proportionately as many of them have become the victims of illness and death, and, furthermore, a much higher proportion of them have become unattached and have resigned. The reasons for these facts are not evident, but it reflects the increasing rate of unattachment and resignation in recent years.

(iv) In the nineteen years between 1950 and 1968, the Church of Scotland has lost 15.3 per cent of its ministerial manpower solely as a result of disability and death. The proportion would be appreciably higher if it were possible to establish how many others have left the ministry for undisclosed health reasons.

Although these facts provide a general impression of the extent to which ill-health affects the ministerial resources of the Kirk, they do not demonstrate whether ministers' rate of death and morbidity has increased to a significant degree. If anything, the fact that the average annual losses due to illness, disability, and death have remained reasonably constant suggests that this is not so. However, in the following chapters we will examine the mortality and morbidity experience of Church of Scotland ministers in detail. This must be done in the perspective of the overall Scottish pattern of mortality and keeping in mind the limitations of mortality and morbidity data as indices of the health of any group.

CHAPTER 9

MORTALITY EXPERIENCE

It has been stated that death is the least equivocal indication of the health of a community or group.⁽¹⁾ Although mortality data may be misinterpreted and may obscure important facts, it serves to give a reasonably clear indication of the effects of being involved in a particular occupation and also provides a means of comparing the experience of different occupational groups. We now turn to examine the mortality experience of Church of Scotland ministers in the period under study, 1930 to 1969. Most attention will be devoted to the life expectation, the rate of death, and the causes of death of this group of ministers.

The main sources for the material presented here were the Decennial Reports of the Registrar General for Scotland on occupational mortality, the records of Register House, actuarial reports presented to the General Assembly, and material provided by the Church and Ministry Department of the Church of Scotland.

The author was presented with two major difficulties in undertaking this particular segment of the study. The specific age distribution of any group is of considerable importance in a study of mortality, and is of particular importance in calculating life expectation and death rates. However, it proved impossible to establish the age distribution of Church of Scotland ministers for any points during the period under study. This imposed serious limitations on the extent and reliability of any calculations which could be made, especially with respect to life expectation and rates of death. It also proved difficult to confine this study exclusively to the experience of parish ministers. Most of

(1) Cf. J. Last, op.cit.

the information available makes no distinction between parish ministers and those engaged in non-parochial ministries, and for the purposes of this mortality study it has been necessary to regard all ministers of the Church of Scotland as a total group. Reference is made to the experience of those in 'specialist' ministries wherever possible.

Despite these technical limitations, however, it has been possible to establish a number of significant facts concerning the mortality of Church of Scotland ministers between 1930 and 1969.⁽¹⁾

1. LIFE EXPECTATION

Ministers of the Church of Scotland have been popularly accredited with notable longevity. This belief has been supported by mortality data available over more than a century,⁽²⁾ which has shown that Protestant clergymen have had a consistently higher life expectation than the male population and than those engaged in other professions. In Scotland this belief has been further reinforced by the fact that some insurance companies have offered special premium rates to Church of Scotland ministers.

Lacking age distribution data, it has not been possible to calculate the life expectation or average length of life of Church of Scotland ministers. Complete death records have been available, however, and from these it has been possible to establish the annual average age of death in order to gain some indication of their life expectation. The

(1) It is frankly acknowledged that some aspects of the following report would not meet the strict requirements of an actuarial investigation. That is unavoidable. There is no official record of the age distribution of the total population of Church of Scotland ministers, which limits the accuracy and reliability of a mortality study. Nevertheless, a number of significant facts can be established.

(2) q.v. Chapter 2.

TABLE 17: COMPARATIVE LIFE EXPECTATION, SCOTLAND, 1920-1969.

YEAR	CHURCH OF SCOTLAND				R.C. SECULAR CLERGY	SCOTLAND			
	TOTAL DEATHS	BIRTH	25	45		BIRTH	25	45	FEM. BIRTH
1920-22	114	68.15	43.15	24.37	-	53.1	.	24.5	56.4
1930-32	290	70.53	45.39	26.61	64.3	56.0	.	25.1	59.5
1942-44	284	70.74	46.08	28.93	66.4	59.8	.	25.7	64.6
1946	99	72.55	47.55	28.63	72.2
1947	92	71.40	46.40	28.42	68.3	61.7	.	.	65.7
1948	78	71.38	46.38	27.78	72.1	63.2	.	.	67.6
1949	84	70.49	45.18	27.54	68.1	64.0	.	.	67.6
1950	86	71.97	46.97	28.45	67.6	64.5	.	25.5	68.7
1951	89	72.81	47.81	28.14	66.6	64.2	.	25.5	68.3
1952	84	74.53	49.53	29.90	64.6	65.16	44.22	25.9	69.58
1953	81	74.66	49.66	29.66	65.4	65.7	44.43	26.2	70.7
1954	78	73.21	48.21	27.41	62.3	65.5	44.1	25.8	70.5
1955	69	73.08	48.08	25.58	65.8	65.8	44.2	25.9	70.6
1956	79	74.32	49.32	30.13	58.1	66.0	44.2	25.8	71.2
1957	78	75.01	50.01	30.77	56.4	66.0	44.3	25.8	71.4
1958	77	75.00	50.00	30.85	62.4	66.2	44.3	25.9	71.4
1959	57	72.7	47.7	27.7	68.4	66.0	44.2	25.7	71.4
1960	52	76.09	51.09	31.09	60.5	66.4	44.5	26.0	71.9
1961	73	75.97	50.97	30.97	62.9	66.1	44.2	25.7	71.8
1962	77	73.74	48.74	29.18	60.8	66.1	44.2	25.8	72.0
1963	63	74.52	49.52	30.08	69.5	65.8	43.8	25.3	71.9
1964	62	74.20	49.20	30.2	66.8	66.7	44.5	26.0	72.8
1965	57	72.41	47.41	27.41	62.1	66.5	44.3	25.8	72.6
1966	61	73.42	48.42	28.42	.	66.6	44.4	25.9	72.5
1967	61	71.31	46.31	26.31	.	67.36	45.0	26.5	73.5
1968	57	71.42	46.42	26.42	.	66.9	44.9	26.1	73.1
1969	46	71.65	46.65	26.65

N.B. The data concerning Church of Scotland and Catholic clergy is based on actual mortality experience with no reference to age specific distribution.

average age of death is a statistically unsatisfactory measure. With a small population it is likely to fluctuate considerably and the smaller the population the less it can be depended upon as a reliable measure. Furthermore, the average age of death bears no relation to the living population and in a population with a high average age the age at death will be high, with a low average age the age at death will be low. Despite these drawbacks, the average age of death for Church of Scotland ministers is the only measure available to us at this point.

In fact, employing this measure, the average age of death of Church of Scotland ministers has been remarkably consistent over a forty year period when one considers the relatively low number of deaths in any year (See Table 17 over). The total variation has been 5.69 years, from 70.40 (1947) up to 76.09 (1960). By comparison, the average age of death of Roman Catholic Secular Clergy in Scotland, with a lower annual number of deaths, has been much more erratic with a variation of 15.8 years, from 56.4 (1957) to 72.2 (1946).⁽¹⁾

In the period 1920-1922, the average age of death for Church of Scotland ministers was 68.15 years which exceeded the Scottish male life expectation at birth (53.1 years) by 15 years. Although these two figures are not directly comparable, it seems to be an unusually large gap and would seem to justify the conviction that Church of Scotland ministers enjoyed good health.

These figures, however, are completely misleading. It is not valid to compare the experience of these ministers with the male expectation at birth. It is self-evident that the Church of Scotland minister has survived the hazards of infancy, childhood, and youth, and has attained at least the age of 15 years. Compared with the

(1) Data for Catholic Secular Clergy derived from The Catholic Directory (Glasgow, 1966).

Scottish male expectation, Church of Scotland ministers showed no great advantage at 15 years of age. In 1920-1922 the Scottish male expectation at 15 was 49.1 years,⁽¹⁾ or a total life expectation of 64.1 years compared with the actual average age of death of 68.15 years for Church of Scotland ministers, that is, an advantage of 4 years. By the age of 45 years they enjoyed no advantage. Based on the deaths occurring in this period, the average Church of Scotland minister could expect a further 24.37 years at age 45 while the average Scottish male could expect a further 24.5 years.

By 1930-1932 the average age of death of Church of Scotland ministers had risen by a little more than two years to 70.53. In the same period, the expectation of Scottish males at birth was extended by almost three years to 56.0 years. It would seem that ministers held an advantage over the male population of five years at 15 years of age (50.53: 50.4), but once again they held no appreciable advantage at 45 years of age (26.61: 25.1).

It is striking that the expectation of Scottish males at birth has risen steadily between 1932 and 1968, from 56.0 years to 66.9 years, by almost fourteen years. The average length of life for females has shown a comparable increase, from 59.5 to 73.1 years. This development illustrates the marked reduction in infant mortality and the steady decline in the death rate in infancy and childhood in that time. Life expectation at the older ages, however, has not risen appreciably. The male expectation at 45 years has not risen significantly (from 25.1 to 26.1 years) in the same period. Improvements in medical and surgical skills, including organ transplants, and in geriatric care have not extended human life to any marked extent. Some theorists

(1) Refer to Appendix II: Table 2B.

doubt whether the human life span can be significantly extended.

R. Dubos and M. Pines, for instance, express the view that death is an inescapable fact of human existence and that there is no immediate prospect of extending human life beyond its present limits: "Even the replacement of worn-out organs by new ones can have only a temporary effect. Patching up one area will merely expose deficiencies in another.When enough body functions fail, the organism dies."⁽¹⁾

In the period since 1946 the average age of death for Church of Scotland ministers has been slightly erratic. The main feature has been an irregular increase in the average age of death from 71.40 in 1947 up to 76.09 in 1960 (Table 17, q.v.). In the nine years from 1956 to 1964 their average age of death exceeded 74 years in all but two years, which represents an advantage over the male length of life of eight to ten years. In 1960, moreover, they held an advantage of five years over the male expectation at 45 years of age.. Although this is a crude and unreliable means of comparison, it does seem to suggest that the health of these ministers has been comparatively positive.

However, there has been an equally marked, although irregular, decline in the average age of death of Church of Scotland ministers since 1960. Having reached a peak of 76.09 years in 1960, it has subsequently fallen to 71.65 in 1969 and has been below 72 years in each of the last three years. Indeed, in 1965 their average age of death fell below the female life expectation (at birth) for the first time (See Table 17, q.v., and Figure 5, following).

Although a group's average age of death is an unsatisfactory measure, some very tentative conclusions may be drawn from these facts.

(1) R. Dubos and M. Pines, op.cit., p. 16.

FIGURE 5 : COMPARATIVE LIFE EXPECTATION , SCOTLAND , 1942 - 1968 .

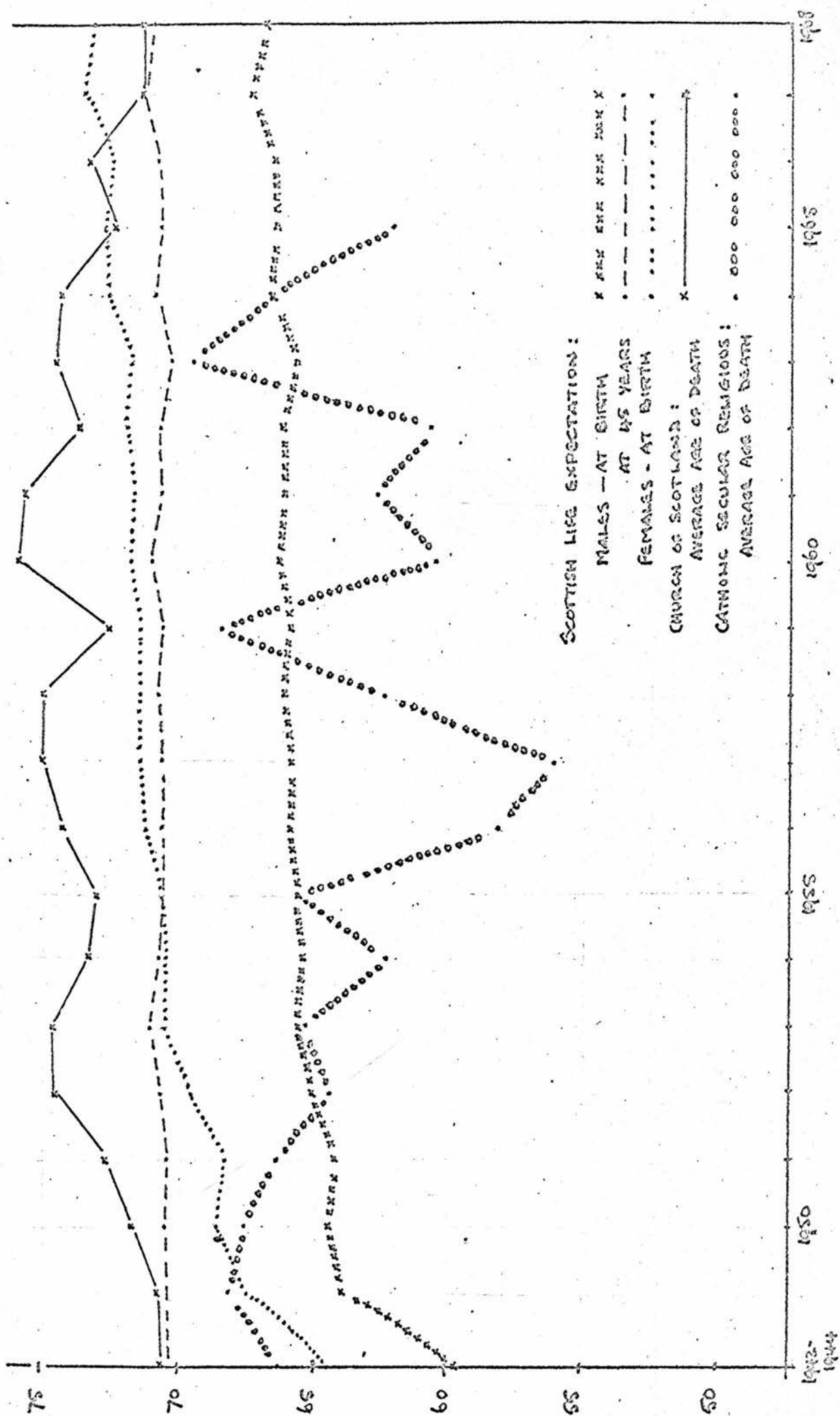
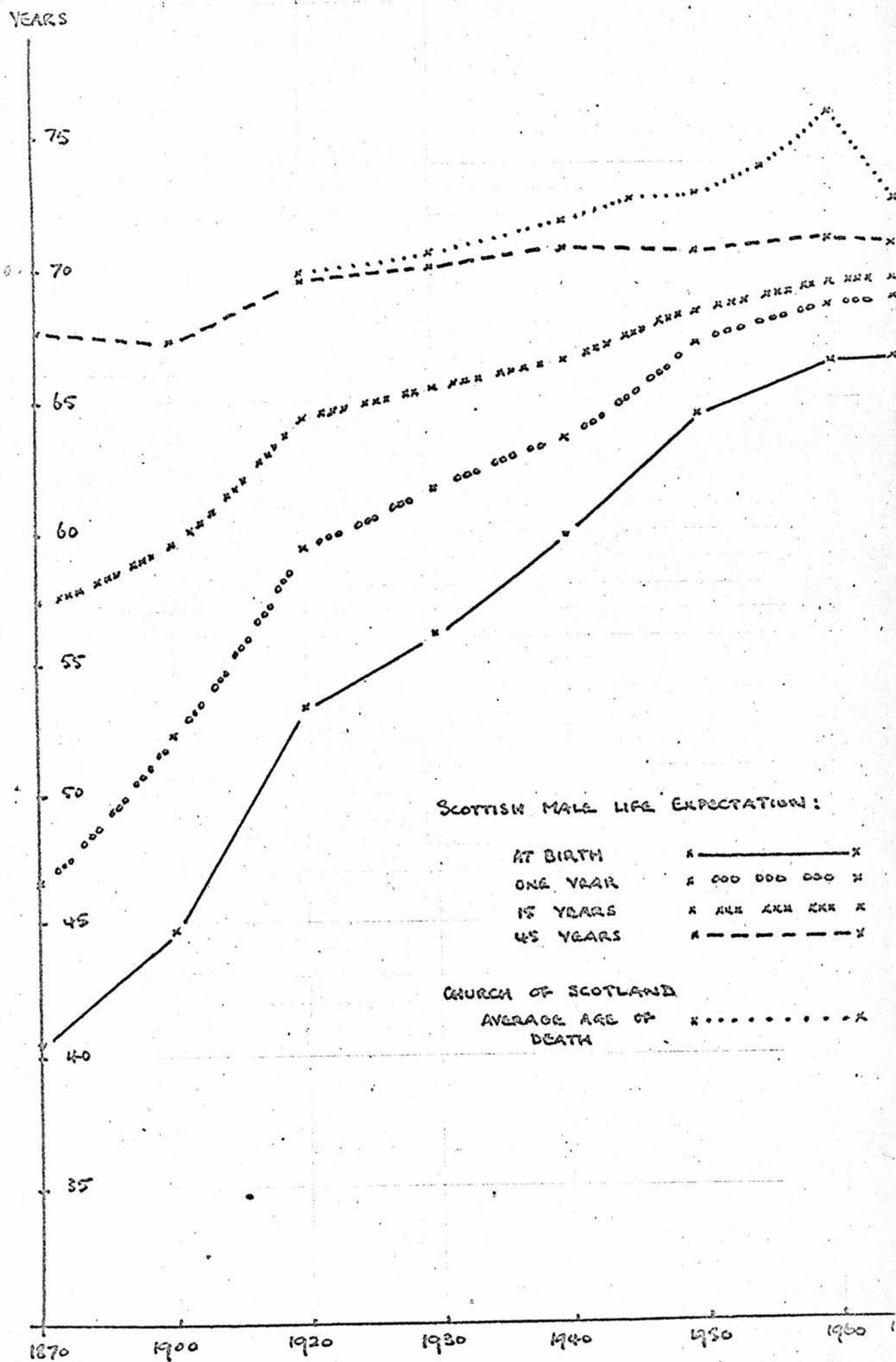


FIGURE 6 : SCOTTISH MALE LIFE EXPECTATION , 1870 - 1965 .



In the first place, the average age of death has consistently exceeded the over-all life expectation of the Scottish male population. On the basis of their actual experience of death, ministers could expect to survive the average Scottish male by fifteen years in 1920-1922. In the meantime this advantage has been reduced to about four or five years with a steady increase in the Scottish male life expectation at birth.

Secondly, this overall advantage is misleading and frankly illusory, as a group's average age of death is not comparable with the population's life expectation at birth. At the age of 15 years, Church of Scotland ministers' advantage has been less marked (Table 18 following). In 1930-32, the minister hypothetically aged 15 years could expect to survive the average male by five years and by 1968 this difference had been reduced to two and a half years.

TABLE 18: COMPARATIVE LIFE EXPECTATION AT BIRTH,
15 YEARS, AND 45 YEARS ⁽¹⁾

Period	Scottish Males			Church of Scotland Clergy		
	Birth	15	45	Birth	15	45
1930-32	56.0	50.4	25.1	70.53	55.53	25.39
1950-52	64.4	53.1	25.5	71.97	56.97	26.97
1960	66.4	54.1	26.0	76.09	61.09	31.09
1968	66.9	54.1	26.1	71.42	56.42	26.42

By the time they reach the age of 45 years Church of Scotland ministers could expect to survive no longer than the average Scottish male. This

(1) With respect to Church of Scotland Clergy these figures apply to their average age of death and to their actual mortality experience.

would suggest that their health experience up to the age of 45 years is favourable but that it tends to decline thereafter.

Thirdly, there is some indication of a decline in the health of Church of Scotland ministers since 1960. Their overall age of death has fallen from 76.09 years to 71.42 years in that period and, although this would suggest that their life expectation still exceeds that of Scottish males in general, it is interesting to note that it has fallen below the average length of life for Scottish females in the last four years. It remains to be seen whether this trend continues but their average age of death has now been consistently below 72 years for three consecutive years, which is more than four years below the 1960 level.

By contrast, the secular clergy of the Roman Catholic Church in Scotland have not enjoyed such a favourable mortality experience. The figures concerning their average age of death (Table 17 and Figure 5, q.v.) are less reliable than those concerning Church of Scotland clergy. They are based on the experience of a much smaller population and many fewer deaths in each year.⁽¹⁾ The average age of death of Roman Catholic Secular Clergy therefore fluctuates considerably from year to year. But over a period of thirty-five years, 1930 to 1965, the picture is remarkably consistent. Up to 1952 their average age of death exceeded the male life expectation but rarely matched that of Church of Scotland ministers. However, since 1952 their average age of death has only once (1963) exceeded the average length of life of Scottish males. This is in sharp contrast to the experience of Church of Scotland ministers.

(1) The average age of death for Roman Catholic Secular Clergy was calculated from information published in The Catholic Directory (1966). The highest number of deaths recorded in any year was 21 (1955): refer to Appendix II - Table 2E.

It has not been possible to establish the life expectation of Church of Scotland ministers. But an examination of their average age of death, for all its inadequacies, leads to positive conclusions even allowing for the possibility of a decline in recent years.

2. THE DEATH RATE OF CHURCH OF SCOTLAND CLERGY, 1930-1969

(i) STANDARDIZED MORTALITY RATIO

The average age of death of Church of Scotland ministers, while it may be suggestive, may be misleading if not totally erroneous. Superficially it would appear that they tend to live to a 'ripe old age' and that their health needs arouse little concern. However, a more accurate and reliable indication of the true state of their health may be gained from an examination of their rate of death.

The decennial reports on occupational mortality prepared by the Registrar General for Scotland provide a valuable aid for this purpose. These reports provide a basis for comparing occupational rates of death and life expectation in the form of Standardized Mortality Ratios (S.M.R.), which compare occupational rates of death with that of the male population.

In the reports of the Registrar General for Scotland all Scottish clergymen are grouped together to comprise one occupational group: "Ministers, Clergymen, and Religious Orders". They make no denominational distinctions, which limits the conclusions which may be drawn with respect to Church of Scotland ministers. However, there are more Church of Scotland clergymen than there are clergymen of all the other denominations put together and, as a group, they comprise in the vicinity of two thirds of the total group of "Ministers, Clergymen,

and Religious Orders".⁽¹⁾ It can therefore be reasonably assumed that their experience closely parallels that indicated by the Registrar General's reports.

The first of these reports was presented for the period 1930-1932.⁽²⁾ During this period, a total of 420 deaths were recorded for this group of Scottish clergymen and 284 of these (i.e. 67.6%) were ordained ministers of the Church of Scotland.

It is evident that the experience of Scottish clergymen compared favourably with other occupations, especially those in the Commercial and Professional Orders, at that time.

The pattern which emerges from these figures corroborates, in part, the conclusions drawn from the data concerning Church of Scotland ministers' average age of death. These figures show that for the working years, ages 25-64 years, the death rate of Scottish clergymen (S.M.R. 85.4) was not only below that of the Scottish population but was also below the death rate experienced by most of these occupational groups. Among the professions, only teachers (S.M.R. 80.2)

- (1) The 1951 Scotland Census published details of the population of clergymen for the main denominations which confirm this point.

1951 SCOTLAND CENSUS:

Denomination	Active	Retired	Total
Church of Scotland	2,485	382	2,867
United Free Church	78	9	87
Episcopal Church	234	39	273
Roman Catholic	969	23	992
Other Religious Bodies	654	121	775

Scotland Census 1951, Vol. IV Occupations and Industries (H.M.S.O. 1956), Table I, p. 18.

- (2) Registrar General for Scotland (1936), op.cit.

TABLE 19 : STANDARDIZED MORTALITY RATIOS BY AGE FOR
SELECTED OCCUPATIONS, 1930-1932⁽¹⁾

Occupation	All Ages 14 years & over	25-64	14-24	25-44	45-64	65+
COMMERCIAL ORDER	96.9	98.4	76	94	100	98
Proprietors and Managers	106.7	106.9	-	111	106	106
Salesmen and Shopassistants	82.2	96.0	63	98	94	74
Commercial Travellers	95.5	93.7	114	80	100	97
Insurance Brokers and Agents	90.2	83.3	-	79	85	95
PROFESSIONAL ORDER	92.9	93.5	44	76	100	96
*Ministers and Clergymen	95.9	85.4	-	62	90	101
Judges, Solicitors etc.	103.5	114.3	-	41	128	104
Physicians and Surgeons	103.7	99.8	-	88	105	108
Teachers	82.6	80.2	-	68	85	86

had a more favourable experience. By contrast, Judges and Solicitors (S.M.R. 114.3) and Proprietors and Managers (S.M.R. 106.9) were above the average rate, while members of the medical profession (S.M.R. 99.8) were close to the male average. This report also revealed that the lowest rates of death were experienced by Agricultural Workers (S.M.R. 69.2) and Fishermen (S.M.R. 78.0); and, at the other extreme, Hotel-keepers (S.M.R. 162.2), Hairdressers (S.M.R. 140.1), and Barmen (S.M.R. 138.6) had the highest rates of death.

These figures also indicate, however, that the health of Scottish clergymen deteriorated rapidly after the age of 45 years, as was suggested by the average age of death of Church of Scotland ministers.

(1) Registrar General for Scotland (1936), op. cit., from Table R, p. lxxiv.

For the ages 25-44 years they had an S.M.R. of 62 which is indicative of a very considerable advantage over the male population for that period of life. Thereafter their rate of death increased rapidly to reach an S.M.R. 90 for the ages 45-64 years. This kind of deterioration was even more marked in the legal profession, who had an unusually low S.M.R. 41 for ages 25-44 years which then rose to S.M.R. 128, to be well in excess for ages 45-64 years.

According to these figures for 1930-32, Scottish clergymen had a favourable expectation of life overall, by comparison with the male population and other professions. However, it is also clear that their rate of death increased appreciably over the age of 45 years.

The next decennial report on Scottish occupational mortality was published with respect to the 1949-53 period.⁽¹⁾ Once again, "Ministers, Clergymen, and Members of Religious Orders" were blocked together in one occupational group, with no denominational distinctions. In this period, 606 deaths were recorded for this group and 420 of these (i.e. 69.2%) were Church of Scotland ministers.

Some important changes had evidently occurred in the mortality of Scottish males and occupational groups. The life expectation of Scottish males had been extended by almost eight years, from 56.0 to 64.4 years (See Table 17, q.v.). This means that mortality ratios, which are relative to the "average", cannot be directly compared for the two periods covered by these reports. Moreover, it is evident that the distribution of occupational mortality ratios had been reduced: Unskilled Occupations (S.M.R. 129.9) had the highest and Building Workers (S.M.R. 71.7) had the lowest mortality ratio in 1949-53. This means, in other words, that all mortality ratios tended to be closer

(1) Registrar General for Scotland (1956), op.cit.

to the average than in the earlier report. Changes had also been made in the classification of occupations and in the age groupings which make it more difficult to compare the two reports.

The following table presents some relevant details drawn from this report, making reference to the same occupational groups listed in the preceding table, together with some additions.

TABLE 20: STANDARDIZED MORTALITY RATIOS BY AGE FOR
SELECTED OCCUPATIONS, 1949-1953⁽¹⁾

Occupation	All Ages 15 years & over	20-64	15-19	20-45	46-64	65+
Fishermen	102.0	87.8	145	109	84	107
Agricultural Occupations	83.3	63.4	(83)	72	61	92
Administrators, Directors and Managers	112.5	88.6	-	73	91	130
Commercial, Finance, and Insurance Order	114.2	105.2	104	88	110	120
Proprietors and Managers	124.0	113.4	(146)	100	116	129
Commercial Travellers	109.5	97.9	-	74	104	118
Salesmen and Shopassistants	90.5	91.5	104	84	95	89
Insurance Brokers and Agents	95.5	90.7	-	84	93	99
Professional and Technical Order	96.2	88.0	(51)	80	91	102
*Ministers, Clergymen etc.	88.3	68.7	-	56	71	96
Judges and Solicitors	104.2	102.5	-	90	106	105
Physicians and Surgeons	111.8	111.7	-	88	118	112
Teachers	80.7	64.2	-	56	66	92
Professional Engineers	103.3	99.1	(121)	91	102	106
Scientists	84.9	82.6	(55)	85	81	91

(1) Reg. Gen. for Scotland (1956), op.cit., derived from Table CC, p.112.

These figures indicate that the mortality experience of Scottish clergymen, including Church of Scotland ministers, had improved by comparison with the male population and most of these occupational orders and groups. For the active working years, 20-64 years, they now had an S.M.R. 68.7 by comparison with S.M.R. 85.4 for ages 15-64 in 1930-32. This is a remarkable fact when it is considered that the average length of life for males had been significantly extended in the same period. Of these occupations, only agricultural workers (S.M.R. 63.4) and teachers (S.M.R. 64.2) had lower rates of death for the same period of life. Indeed, for the ages 20-45 years Scottish clergymen (S.M.R. 56) had the most favourable experience of all these occupational groups.

It is also evident from these figures that the death rate of Scottish clergymen did not increase to such a marked extent over the age of 45 years, although, as in the earlier information, their death rate did increase progressively with age. From an extremely low S.M.R. 56 for ages 20-45, their death rate increased to an S.M.R. 70 for ages 46-64 years, which is appreciably lower than that recorded in 1930-32. Again, only agricultural workers (S.M.R. 61) and teachers (S.M.R. 66) among these occupations had lower rates of death for the 46-64 age group.

Both these reports indicate, in terms of death rates and life expectation, that Scottish clergymen have had a favourable health experience at least up until the early 1950s. In both of these periods their rate of death for all age groups has been appreciably lower than the male population and lower than most other professional groups, including members of the legal and medical professions. Within the Professional and Technical Order, only the experience of teachers has been consistently more favourable. On this basis, Scottish clergymen would rank among the healthiest occupational groups in Scotland.

It is also evident that their experience was most favourable in the younger age groups, with an unusually low rate of death up to about the age of 45 years. In the following years, 45-64 years, their rate of death has risen appreciably, although this was less marked in 1949-53 (See Table 21, following).

TABLE 21 : STANDARDIZED MORTALITY RATIOS BY AGE FOR SELECTED OCCUPATIONS, 1930-32 AND 1949-53

Occupation	1930-1932			1949-1953		
	25-44	25-64	All Ages 14 years & Over	20-45	20-64	All Ages 15 years & Over
Professional & Technical Order	76	93.5	92.9	80	88.0	96.2
*Ministers, etc.	62	85.4	95.9	56	68.7	88.3
Judges, etc.	41	114.3	103.5	90	102.5	104.2
Physicians, etc.	88	99.8	103.7	88	111.7	111.8
Teachers	68	80.2	82.6	58	64.2	80.7
Professional Engineers	-	-	-	91	99.1	103.3
Scientists	-	-	-	85	82.6	84.9
Proprietors, Managers, etc.	111	106.9	106.7	100	113.4	124.0
Administrators, Directors, etc.	-	-	-	73	88.6	112.5

Another fact to emerge from this data is that the death rate and life expectation of Scottish clergymen, particularly in the younger age groups, had apparently improved relative to the male population in this period of time. Their mortality ratio was relatively more favourable at every age in the later report. Whether this positive record of good health, measured in terms of mortality ratios, has been maintained since 1951 remains to be seen.* No more recent data has yet

been published, although a report for the five years around 1961 may become available in the near future.

It is unfortunate that these reports make no interdenominational comparisons possible. In view of the relatively small numbers involved such a breakdown is neither feasible nor warranted for the purposes of a statistical report of this kind. However, it is safe to assume that the Registrar General's data closely approximates the experience of Church of Scotland ministers who comprise almost two thirds of this occupational group.

(ii) DEATH RATE, 1930-1968

The virtual impossibility of establishing the specific age distribution of Church of Scotland ministers⁽¹⁾ has made it difficult to gain a more detailed and sufficiently reliable indication of their rate of death in the period under study. Undoubtedly the most reliable indication of changes in the death rate of Church of Scotland ministers has been provided by the actuarial investigations conducted on behalf of the Aged and Infirm Ministers' Fund Committee.⁽²⁾ These investigations have been conducted at quinquennial intervals.

(1) No official record of the age distribution of all Ordained Ministers of the Church of Scotland, both active and retired, is maintained. The Scotland Census 1951 provides some indication of their age distribution at that time, but cannot be relied upon for statistical purposes especially as the census did not cover all ministers such as those actively engaged beyond Scotland. The actuary for the Aged and Infirm Ministers' Fund was able to provide accurate figures for the age distribution of contributors to the fund, but these represent only a proportion of the total population. The only possibility would have been to establish the age of every Ordained Minister listed in the Church's Year Book at regular intervals. This would obviously be a mammoth task and it was doubtful whether it would add to this project to an appreciable extent.

(2) q.v. Chapter 2.

The actuary's reports are based on the experience of ministers who contribute to the pension fund. This does not include all ministers of the Church of Scotland. But since 1958, when membership became compulsory for all ordained ministers under 50 years of age, the reports have been applicable to a majority of them. In fact the number of members has grown steadily from about 935 in 1957 to 1,633 in 1967, which is something more than half the total active and retired ministers of the Church of Scotland.

Up to 1953, as we have seen,⁽¹⁾ the actuarial reports presented to the General Assembly confirmed and supported the confidence held in the health of Church of Scotland ministers. According to the reports submitted in 1948 and 1953, the mortality of contributors and pensioners in the fund was not excessive during the period 1942-1952. In fact, the actuary reported that deaths among them had been considerably fewer than expected in the later quinquennium, 1948-1952. These general findings were consistent with the information provided by the Registrar General's reports up to that time.

However, it is apparent that the death rate of Church of Scotland ministers, as represented by members of the fund, underwent significant changes during the next decade. In a special report in 1956, the actuary observed that deaths in the 70-74 age group, in the five years normally following retirement, had been about 80 per cent in excess of normal for this age group. In a further report in the following year, submitted to the General Assembly in 1958, it was disclosed that deaths for all ages over 70 years continued to be excessive, being some 40 per cent in excess of expectations. Moreover, it was found that there had also been a substantial rise in deaths in the 65-69 age group, which were now double

(1) Refer to Chapter 2, q.v.

those expected. The increasing rate of death among ministers in the 65-74 age range was unmistakable and gave cause for concern. In the younger ages under 65 years, however, the death rate remained within normal limits during this period.

This development continued over the next five years, as was disclosed in the actuary's report to the General Assembly in 1964. The actuary found that the rate of death in the years immediately preceding and following retirement continued to be excessive, while mortality for other age groups remained within expected limits. The figures calculated by the actuary substantiate these general findings.⁽¹⁾

As is indicated in the following table, the overall mortality of active ministers, 1958-1962, was in excess of expected deaths. The actuary recorded 40 actual deaths for all ages as against 33.995 'expected' deaths.⁽²⁾

- (1) The assistance of Mr. J.B. Dow, actuary to the Aged and Infirm Ministers' Fund Committee, is gratefully acknowledged. Mr. Dow has been responsible for the actuarial investigations reported to the General Assembly in 1964 and 1968, and the tables provided by him are presented with the permission of Rev. K. Greenlaw, Secretary of the Church and Ministry Department of the Church of Scotland.

Mr. Dow is also an actuary of the Episcopal Church Fund and in a personal communication to the author he observed: "Their fund has about 300 members and is not statistically very easy to handle. The distribution of lives according to age is very similar to that of the Church of Scotland, and the mortality experience, so far as one can tell from the small numbers involved, is also roughly the same."

- (2) For the purposes of these investigations, Expected Deaths have been calculated by the A55 ultimate table.

TABLE 22(a): CHURCH OF SCOTLAND CONTRIBUTORS' PENSION FUND:
MORTALITY OF ACTIVE MEMBERS, 1958-1962

Age	Exposed to Risk	Actual Deaths	Expected Deaths
25	18	-	.023
30	368	-	.512
35	643	-	1.080
40	915.5	1	2.101
45	1,274	6	4.446
50	1,223.5	5	6.693
55	610.5	8	5.311
60	276.5	7	3.877
65	151.5	7	3.480
70	109	6	4.116
75	22.5	-	1.387
80	7.5	-	.740
85	1.5	-	.229
		40	33.995

From these figures it can be seen that deaths in the 50-69 age range, with 28 actual deaths as to 16.784 expected deaths, were significantly in excess, being almost double those expected. This excess was most marked in the 60-69 age group, with 13 actual deaths as to 7.596 expected deaths. In the younger and older age groups, under 50 years and over 70 years, the mortality of active ministers was below expectations.

The mortality of pensioners for 1958-1962 also showed an overall excess, with 34 actual deaths as to 30.489 expected deaths. As the actuary reported, the greatest excess in deaths was most evident in the 65-74 age group. These were almost double those expected, with 13 actual deaths as to 7.613 expected deaths.

TABLE 22(b): CHURCH OF SCOTLAND CONTRIBUTORS' PENSION FUND:
MORTALITY OF PENSIONERS, 1958-1962

Age	Exposed to Risk	Actual Deaths	Expected Deaths
70	49	4	1.850
75	93.5	9	5.763
80	70.5	6	6.952
85	36.5	3	5.565
90	22	7	4.931
95	15	4	4.635
100	2	1	.793
		34	30.489

However, the following report, with respect to 1963-1967, offered some signs of an encouraging improvement. The actuary found that mortality during this period had been somewhat lighter than at previous valuations. The total number of deaths among active ministers, with 47 actual as to 49.939 expected deaths, was marginally below expectations which is a reversal of the experience for 1958-1962.

In this period, deaths for all ages under 65 years have been below expectations, with 43 actual deaths as to 46.229 expected deaths. In particular, deaths in the 50-54 age group were substantially below expectations. However, deaths in the 60-69 age group continued to be excessive, with 11 actual deaths as to 8.229 expected deaths, and were particularly excessive in the 60-64 age group. Therefore, although there had been an overall improvement in the mortality of these

ministers, the number of deaths occurring in this particular age group from 60-69 years continued to be a cause for concern.

TABLE 23(a): CHURCH OF SCOTLAND CONTRIBUTORS' PENSION FUND:
MORTALITY OF ACTIVE MEMBERS, 1963-1967

Age	Exposed to Risk	Actual Deaths	Expected Deaths
25	66	1	.084
30	474	-	.659
35	884	-	1.485
40	938	1	2.157
45	1,285	6	4.485
50	1,785	10	9.764
55	1,580	9	13.746
60	588	7	8.244
65	244	9	5.605
70	69.5	2	2.624
75	11.5	2	.709
80	1.5	-	.148
85	1.5	-	.229
		47	49.939

The mortality of pensioners was also more favourable than the experience reported in the earlier investigation. The number of deaths in this group, 21 actual deaths as to 26.586 expected deaths, was now below expectations.

TABLE 23(b): CHURCH OF SCOTLAND CONTRIBUTORS' PENSION FUND:
MORTALITY OF PENSIONERS, 1963-1967

Age	Exposed to Risk	Actual Deaths	Expected Deaths
70	54.5	2	2.058
75	106.5	3	6.565
80	67.5	5	6.656
85	47.5	8	7.242
90	14	2	3.138
95	3	1	.927
		21	26.586

By contrast with the reports presented in 1956, 1958, and 1964, these figures do not reveal any excess of deaths in the 65-74 age range. As a matter of fact, for the first time in a decade, deaths in the 70-74 age range were fewer than expected.

In general, then, these actuarial reports have presented a favourable picture of the health of Church of Scotland ministers which is consistent with the earlier findings drawn from an examination of their average age of death and from the reports of the Registrar General for Scotland. Their experience has been most consistently favourable in the younger and older age groups, under 50 years and over 75 years. However, since 1956 they have also disclosed a significant increase in mortality in the 60-74 age range. This development has been most marked and most persistent in the 60-64 age group, although the most recent information suggests that mortality in the 70-74 age group may no longer be so excessive as is indicated in earlier reports.

The positive picture presented by the last of these actuarial reports, for 1963 to 1967, would suggest that the decline in the average age of death referred to earlier is not an accurate indication of Church of Scotland ministers' health. However, this decline has been most apparent in the last three years, 1967-1969, a period not covered by the actuary's investigation. There is a possibility that deaths in the 55-64 age group may have increased very significantly in these last few years. As a matter of fact, the proportion of actual deaths occurring in the 55-64 age group has risen suddenly and substantially between 1966 and 1969. The proportion of deaths occurring in any age group, without reference to the age distribution of the live population, is a most unreliable and suspect measure of mortality. However, the facts are worth examination.

TABLE 24 (a): TOTAL ACTUAL DEATHS OF CHURCH OF SCOTLAND
CLERGY BY AGE, 1920-1969*

Year	Total Deaths	25-	35-	45-	55-	65-	75-	85-	Total Deaths -65
1920-22	115 (106)	2	3	7	26	34	24	10	38
1930-32	290 (288)	1	8	12	49	100	87	31	70
1942-44	284 (281)	8	13	9	23	80	119	29	53
1946-50	439 (432)	5	15	18	65	122	165	42	103
1951-55	401 (395)	1	3	21	63	117	127	63	89
1956-60	343 (341)	2	4	20	49	82	119	65	75
1961-65	332 (331)	-	3	21	48	75	120	64	72
1966-69	225 (224)	1	-	13	57	42	84	27	71

*(Note: The figures in brackets under total deaths refer to the number of deceased clergymen whose ages of death have been established. Also note that the deaths during 1940-42 include war casualties which accounts for the relatively high number of deaths in the younger ages.)

TABLE 24(b): PROPORTION OF DEATHS OCCURRING IN AGE GROUPS
EXPRESSED AS A PERCENTAGE OF TOTAL DEATHS

Year	Total Deaths	25-	35-	45-	55-	65-	75-	85-	Total Deaths -65
1920-22	106	1.88	2.83	6.60	24.52	32.07	22.64	9.41	35.84
1930-32	288	0.34	2.77	4.16	17.01	34.72	30.20	10.75	24.28
1940-42	281	2.84	4.62	3.10	8.18	28.4	42.34	10.20	18.84
1946-50	432	1.15	3.47	4.16	15.04	28.24	38.19	9.72	24.24
1951-55	395	0.25	0.75	5.31	15.94	29.61	32.15	15.94	22.27
1956-60	341	0.58	1.17	5.86	14.36	24.05	34.60	19.09	21.97
1961-65	331	0.0	0.91	6.34	14.50	22.35	39.27	19.33	21.75
1966-69	225	0.44	0.0	5.80	25.44	18.75	37.50	12.05	31.69

It must be strongly emphasized that these figures may be seriously misleading. There are only two reliable methods for investigating and comparing death rates: either by comparing actual deaths for a given population with expected deaths calculated from a standardized life table, as is done by the actuary or by calculating the actual deaths as a proportion of the live population to give the deaths per 1,000 or per 10,000 experienced by a given population. In either case the important fact is that deaths occurring in a particular age group are obviously relative to the live population in that age group, which is not taken into account in the figures presented in these tables.

Allowing for this important qualification, some outstanding features emerge from these figures. In the first place, the age distribution of deaths for Church of Scotland ministers has been remarkably constant from 1930 up to 1965 and has shown few marked variations. The highest proportion of deaths has consistently occurred in the 75-84 age range and it is also apparent that a substantial proportion of ministers

have survived 85 years. The high proportion surviving 75 years has served to maintain what appears to be a high average age of death, referred to earlier in this chapter.

However, the figures for the most recent period, 1966-69, are at variance with the pattern established through the preceding thirty-five years, 1930-1965, in two respects. The proportion of deaths in the oldest age group, over 85 years, has fallen by 7 per cent on that of the preceding five years. At the same time, moreover, the proportion of deaths occurring under 65 years of age has increased by almost 10 per cent, to exceed more than 30 per cent of the total deaths for the first time since 1920-22. Indeed, deaths under 65 years in 1967 represented 37.7 per cent of all deaths among Church of Scotland ministers, which is an increase of 14 per cent on the proportion for 1966.⁽¹⁾ This increase has occurred almost exclusively in the 55-64 age group with 25.4 per cent of all deaths in 1966-69, an increase of 11 per cent on the preceding period.

These crude figures should be viewed with caution as they simply describe the experience of ministers deceased in a given period of time. Whatever the significance of these figures, the fact is that a greater proportion of deaths have occurred in the 55-64 age range and proportionately fewer have died in excess of 85 years since 1966 leading to the lower average age of death overall. On the surface, these facts suggest that appreciably more Church of Scotland ministers are dying younger and fewer are surviving to the older ages than was previously true.

Now, this disturbing conclusion may not be valid. It may well be that these recent developments simply reflect changes in the age distribution of Church of Scotland ministers. However, this is unlikely.

(1) For the annual distribution of deaths from 1950-1969 refer to Appendix II: Table 2C and 2D.

It is improbable that such a sudden and substantial increase in deaths in the 55-64 age range could be entirely explained by a shift in age distribution. This cannot be stated with absolute certainty; but, from what is known of their age distribution, it is an unlikely explanation. It is known, for example, that the average age of Church of Scotland ministers has been steadily rising and now exceeds 50 years of age. Under these circumstances one would expect an increase in the proportion of deaths in the older age ranges. In fact, the opposite has occurred: deaths in the 65-74 age range have decreased (from 29.61 per cent in 1951-55 down to 18.75 per cent in 1966-69) while those in the 55-64 age group have increased.

It may be, as an alternative explanation, that these developments are the outcome of wide annual variations in the distribution of deaths experienced by a relatively small population. This too is unlikely and cannot be sustained by the facts. The fact is that the distribution of deaths in 1966-69 clearly deviates from the consistent pattern established over thirty-five years. Moreover, deaths in the 55-64 age range have comprised approximately one third of the total deaths in each of the last three years, 1967-1969.⁽¹⁾ In other words, it does not appear to be a random occurrence inflated by the experience of one particular year.

The conclusion that more Church of Scotland ministers have been dying prior to retirement in recent years and that their overall life expectation and longevity has been reduced in consequence seems to be inescapable. However, the extent and seriousness of this development cannot be estimated without more accurate data concerning the age distribution of the live population, and unfortunately no up to date

(1) See Appendix II: Table 2D.

actuarial information is available which might corroborate or invalidate this general conclusion. It will be interesting to see whether it is supported by the next actuarial investigation due to be conducted in 1973 with respect to the mortality experience of 1968-1972.

3. LONGEVITY

According to all the available evidence, Church of Scotland ministers have had an outstanding record of longevity. Their life expectation has clearly exceeded that of the Scottish male population and has compared favourably with members of other professions. Their experience of longevity has only been matched by that of teachers, among the professions in Scotland. It would appear that this record has been sustained until very recent years.

This record of longevity has been due to the high proportion of the Kirk's ministers who evidently survive 75 years of age. If the proportion of deaths occurring in this age group is any guide, then about half of the Church's ministers could expect to survive 75 years. In 1961-1965 59 per cent of all deaths occurred in this age group, although the proportion has fallen to 49 per cent in 1966-1969 (See Table 24(b), q.v.).

The long-term survivors who achieve notable longevity are an interesting group of men. It has been reasonably common for the Kirk's ministers to continue their active ministry beyond the official retiral age of 70 years. At the 1951 Scotland Census, 159 ministers aged 70 years or more (i.e. 6.3%) were still actively engaged in the ministry of the Church of Scotland, and 75 of these were aged 75 years or more.⁽¹⁾ It is not unknown for ministers to continue their active ministry

(1) Scotland Census 1951: Vol. IV Occupations and Industries (H.M.S.O. 1956), p. 62.

well into their 80s, and in a few instances into their 90s.⁽¹⁾ Many more continue to be active following retirement as Senior Colleagues, part-time Senior Assistants, and as Locum Tenens in vacant charges.

In the ten years from 1959 to 1968 a total of 111 Church of Scotland ministers died in excess of 85 years and they might be taken as representative examples of the long-term survivors. Some interesting features emerge from an examination of the external features of their personal histories.

All of these men were ordained prior to the union of the Church of Scotland and the United Free Church in 1929. At the time of the union there were 1,702 Church of Scotland parishes compared with 1,484 United Free parishes, and the United Free Church represented 46.6% of the total. It is interesting to note, however, that 68 (i.e. 61.2%) of the 111 men who died in excess of 85 years between 1959-1969 were formerly ministers of the United Free Church.

The majority of these men, 87 (i.e. 78%), were ordained between the ages of 25 and 34 years. This is consistent with the general pattern for the Church of Scotland ministry. Only 6 had entered the ministry after reaching the age of 40 years.

A clear majority of these men had been married, and a number had survived their spouse by several years. A total of 99 (i.e. 89%) had been married and, of these, 9 had been married twice. None of these men had been divorced. Only 12 were bachelors. This contrasts with the general experience of Church of Scotland ministers: at the time of the 1951 Census 75% were married men.

Their occupational experience is of particular interest.

- (1) The death was recently recorded, for example, of the Kirk's oldest minister, Rev. Joseph Shillinglaw, who died at the age of 97 (Life and Work, September 1970). It is interesting to note that Dr. Shillinglaw retired from active ministry in 1965, at the age of 92 years.

TABLE 25: OCCUPATIONAL HISTORY CHURCH OF SCOTLAND MINISTERS
DECEASED 85 YEARS AND OVER, 1959-1968:
NUMBER OF PARISHES AND YEARS IN LAST PARISH

Years in Last Parish	PARISHES							Total
	1	2	3	4	5	6	7	
-5	-	-	2	-	-	-	-	2
5/9	-	3	2	2	1	1	-	9
10/19	-	4	11	4	5	1	-	25
20/29	1	11	5	8	-	-	-	25
30/39	7	13	6	3	-	-	-	29
40+	11	8	2	-	-	-	-	21
Total	19	39	28	17	6	2	0	111

These figures reveal two unusual facts. Firstly, these long-term survivors had evidently been less mobile than is generally true of Church of Scotland ministers. Most of them (77.5%) had occupied three or fewer parishes throughout their active ministries: 19 had devoted their entire careers to one parish and a further 32 had remained in their second parish for more than twenty years. Most of these men had spent their entire working lives in rural areas or relatively small country towns. Secondly, most of these men (67.5%) had spent more than twenty years in their last parish prior to retirement or death. These facts would suggest that these men generally had more settled lives than is usually true of Church of Scotland ministers, who change parishes every seven years on average, and who would expect to occupy four or five parishes in a total ministry over forty years.

It is also interesting to note that most of these men had continued in the active ministry beyond the usual age of retirement. Eighty one (i.e. 73%) had continued beyond 70 years of age. Most of these (45),

however, did retire between 70-74 years and a further 25 retired between 75-79 years. Of the remainder, 10 had retired between 80-89 years, one in his 90s, and another 10 had remained in the active ministry right up to the time of their death.

To generalize, it can be said that most of these long-term survivors had been married and relatively few had been bachelors; a majority had been formerly ministers of the United Free Church prior to union; as a group they had been significantly less mobile and more settled than is usually true of Church of Scotland ministers, and most had spent their working lives in rural and small country town communities; and most of these had continued in the active ministry well beyond the usual age of retirement, in some instances maintaining a pastoral tie with their parish up to the time of their death.

4. CAUSES OF DEATH

Causes of death may provide an indication of unhealthy conditions experienced by members of an occupational group. They may provide insight into the peculiar health hazards to which they are exposed as a group.

The only available evidence of the causes of death experienced by Scottish clergymen is contained in the Registrar General's decennial reports on occupational mortality. As mentioned earlier, these reports have limitations. In particular, they do not differentiate clergymen on a denominational basis; they refer to Scottish clergymen as a composite occupational group. However, Church of Scotland ministers form a large proportion of that total population and these reports, therefore, provide a valuable guide to their health experience. These reports also have the advantage of facilitating extensive comparisons between the experience of occupational groups.

It has been possible to supplement the information gained from the Registrar General's reports by an examination of the death records of Church of Scotland ministers in recent years. In particular, the author has undertaken a close study of the causes of death in the experience of Church of Scotland ministers who died under 70 years of age between 1958-1967, which yielded more recent information than was available in the Registrar General's reports.

(i) CAUSES OF DEATH, 1930-1932⁽¹⁾

The principal causes of death for Scottish clergymen in 1930-1932 were heart diseases, cerebral haemorrhage, and malignant neoplasms, followed by chronic nephritis, other circulatory diseases, pneumonia and bronchitis (See Table 26, following). This general pattern deviated from the experience of the male population in two respects: deaths from the principal circulatory diseases, such as heart diseases, cerebral haemorrhage, chronic nephritis, general arteriosclerosis and hypertension, tended to be excessive, while deaths from tuberculosis, bronchitis, pneumonia, and, to a lesser extent, cancer were below expectations. This pattern seems to have been characteristic of most occupational groups in the Professional Order.

Heart diseases were obviously the greatest cause of death among Scottish clergymen at that time, as it was for the male population in general. From these crude figures, it would seem that the proportion of deaths from heart diseases among clergymen was greatly in excess of expectations, as it was for most professional groups. The only exceptions were teachers, who were close to the male average in this respect. It is worthy of note that this feature of their experience

(1) Registrar General for Scotland (1936), op.cit.

TABLE 26: PROPORTION OF DEATHS FROM PRINCIPAL CAUSES FOR
THE MALE POPULATION AND FOR SELECTED OCCUPATIONS,
1930-1932 (Percentages)*

Cause	Scottish Male Population	Clergymen	Solicitors	Physicians & Surgeons	Teachers
Heart Diseases	18.01	27.3	23.6	23.8	18.6
Malignant Neoplasms	12.9	11.6	17.1	11.4	13.6
Cerebral Haemorrhage	11.9	15.4	14.04	11.9	14.3
Tuberculosis	7.00	-	-	-	4.6
Pneumonia	6.6	3.5	4.1	7.6	6.3
Bronchitis	6.02	3.09	4.4	-	-
Chronic Nephritis	3.5	5.2	3.7	4.6	3.7
Other Circulatory Diseases	3.06	4.5	3.7	5.1	4.1
TOTAL DEATHS	76,125	420	292	235	535
CENSUS POPULATION (1931)	1,708,280	4,922	3,467	3,886	11,365

* Note: These calculations have been made on the data contained in the report of the Registrar General for Scotland (1936), op.cit. It is important to note that these figures apply to the crude proportions of all deaths and have not been adjusted for age or according to the total populations at risk. The proportions for the male population are for deaths at all ages and are not therefore directly comparable with the occupational data. Diseases of infancy, violence, and old age, which ranked 6th, 8th, and 9th respectively in total deaths, have not been included.

is consistent with the findings of the Registrar General for England and Wales⁽¹⁾ for the same period. Deaths from coronary heart disease,

(1) Registrar General for England and Wales (1938), op.cit. Refer to Chapter 2, q.v.

in particular, among Anglican clergymen (S.M.R. 218) and other Protestant clergymen (S.M.R. 211) in England and Wales were very significantly in excess of expectations at that time, and this phenomenon was evident throughout the Professional Order.

It would appear that deaths from vascular lesions affecting the Central Nervous System were also excessive among Scottish clergymen. These were the second greatest cause of death for clergymen and for members of the medical and educational professions, while deaths from malignant neoplasms were the third greatest cause of death for each of these groups. This is the reverse of the experience of the male population in general. It is a corollary then that cancer caused fewer deaths in these professional groups than would be expected; which is borne out by the Registrar's analysis of comparative mortality ratios (Table 27, following).

It can be seen from these details that the experience of Scottish clergymen was particularly favourable with respect to tuberculosis and bronchitis-pneumonia. It was reported that the greatest reduction in deaths in the preceding decade had been in deaths from pulmonary tuberculosis,⁽¹⁾ although this disease continued to be a major cause of death. The rate of death from respiratory tuberculosis was comparatively low throughout the Professional Order (S.M.R. 67), but Scottish clergymen (S.M.R. 31) had the lowest rate of death from this disease for all occupational groups, followed by agricultural workers (S.M.R. 48). At the other extreme, stonemasons (S.M.R. 325) had an extraordinarily high rate of death from tuberculosis, followed by hairdressers (S.M.R. 185).

(1) Registrar General for Scotland (1936), *op.cit.*, p. xxvii.

TABLE 27: MORTALITY OF MALES (14 YEARS AND OVER) FROM CERTAIN MAIN CAUSES FOR SELECTED OCCUPATIONS* COMPARED WITH THAT OF ALL MALES (= 100), 1930-32⁽¹⁾

Occupation	Tuberculosis		Malignant Neoplasms	Bronchitis Pneumonia
	Respiratory	Others		
COMMERCIAL ORDER	88	77	92	87
Proprietors and Managers	96	87	96	91
Salesmen and Shopassistants	80	69	84	76
Commercial Travellers	87	-	102	84
Insurance Brokers and Agents	46	-	99	101
PROFESSIONAL ORDER	67	78	91	67
Ministers, Clergymen, etc.	31	-	81	51
Solicitors, etc.	-	-	130	73
Physicians and Surgeons	73	-	88	69
Teachers	78	-	84	57

The incidence of deaths from bronchitis-pneumonia also showed marked occupational variations and once again Scottish clergymen (S.M.R. 51) had a particularly favourable experience. Only fishermen (S.M.R. 47) had a lower rate of death from bronchitis-pneumonia, although a number of occupations also had relatively favourable records including farmers (S.M.R. 56), teachers (S.M.R. 57), physicians and surgeons (S.M.R. 69), and solicitors (S.M.R. 73).

The overall death rate from cancer had been steadily increasing but its incidence showed no marked occupational variations, being clustered

(1) Data derived from Registrar General for Scotland (1936), op.cit., Table S, p. lxxvi.

around the average (i.e. 80-120). Nevertheless, it is interesting to observe that Scottish clergymen (S.M.R. 81) had the lowest occupational death rate from all forms of cancer, closely followed by teachers (S.M.R. 84). By contrast, solicitors (S.M.R. 130) experienced an unusually high rate of death from malignant neoplasms, which was well above the experience of the Professional Order as a whole (S.M.R. 91).

The Registrar General reported that both violence⁽¹⁾ and suicide⁽²⁾ were increasing in importance as causes of death. All forms of violence, including accidents in the home, on the roads, and in industry, and criminal violence, accounted for 3,738 deaths in the male population over 14 years, that is a death rate of 21.8: 100,000. A total of 1,047 deaths were attributed to suicide.

TABLE 28: ACTUAL AND EXPECTED DEATHS FROM VIOLENCE, SUICIDE, AND DIABETES, 1930-1932⁽³⁾

OCCUPATION	VIOLENCE		SUICIDE		DIABETES	
MALE POPULATION ALL AGES OVER 14 YEARS	21.8:100,000		6.1:100,000		3.6:100,000	
	Actual	Expected	Actual	Expected	Actual	Expected
Ministers etc.	8	10	2	3	10	2
Solicitors etc.	8	7	5	2	5	1
Physicians etc.	4	7	4	2	4	1
Teachers	18	23	5	7	6	4

The total number of deaths attributed to these causes are too small for statistical reliability to be established. But on the basis of these

(1) Registrar General for Scotland (1936), op.cit., p. lxxx.

(2) Ibid., p. ix.

(3) For more details refer to Appendix II: Table 2G.

calculations, it is probable that deaths by violence and suicide were close to expectations among Scottish clergymen. By comparison, teachers experienced fewer deaths than expected from both these causes, and members of the legal and medical professions seem to have had excessive deaths by suicide. Although the total number of deaths recorded were few, deaths among each of these professional groups from diabetes mellitus appear to have been significantly excessive. There is no explanation for this phenomenon, but it has been frequently observed⁽¹⁾ that diabetes tends to be more common among the professions and occupations in Social Class I.

With reference to the health of Scottish clergymen, the outstanding features of this report are the comparatively high incidence of death from heart diseases and from other circulatory diseases, on one hand, and the exceptionally low frequency of death from both tuberculosis and from bronchitis-pneumonia. It also appears that the prevalence of deaths from cancer was unusually low among Scottish clergymen during this period. In each respect these findings are consistent with the report of the Registrar General for England and Wales for the same period.⁽²⁾

(ii) CAUSES OF DEATH, 1949-1953⁽³⁾

It appears that some notable changes occurred in the mortality experience of Scottish clergymen over the next twenty years, as is indicated by the Registrar General's report on occupational mortality for 1949-1953. It is important to note, as pointed out earlier, that the reports for 1930-32 and 1949-53 cannot be directly compared. Important changes had occurred in the mortality experience of the

(1) For example refer to Registrar General for England and Wales (1938), op.cit.

(2) Refer to Chapter 2, q.v.

(3) Registrar General for Scotland (1956), op.cit.

population and changes had been made in the classifications of occupations and diseases. It is therefore only possible to make a general comparison of the data which they contain.

The principal causes of death experienced by Scottish clergymen remained basically the same as in the earlier period: heart diseases, vascular lesions affecting the Central Nervous System, and malignant neoplasms, followed by other circulatory diseases (such as arteriosclerosis and hypertension), bronchitis, pneumonia, and hyperplasia of the prostate. The general pattern is basically the same, but some significant changes can be observed.

The most outstanding development is the spectacular increase in the proportion of deaths attributable to all forms of heart disease. Among Scottish clergymen the proportion of deaths due to heart disease had risen from 27.3 per cent in 1930-32 to 46.6 per cent in 1949-53. A similar increase had occurred in the male population, from 18.01 per cent up to 34.7 per cent, and the Registrar General noted that there had been a particularly marked increase in the prevalence of coronary thrombosis in the male population. Another feature is that the incidence of chronic nephritis among Scottish clergymen had been reduced to insignificance, while diseases of the prostate had assumed greater importance.

In general, however, the pattern of mortality of Scottish clergymen was similar to that established in the earlier report. Unquestionably, the most outstanding feature of this report is the spectacular increase in deaths from heart diseases, especially from coronary thrombosis.⁽¹⁾ The data contained in this report highlights the particular relevance of coronary heart disease when considering the health of Scottish clergymen.

(1) Registrar General for Scotland (1956), *op.cit.*, p. 34.

TABLE 29: PROPORTION OF DEATHS FROM PRINCIPAL CAUSES FOR THE
MALE POPULATION AND FOR SELECTED OCCUPATIONS,
1949-1953 (Percentages)⁽¹⁾

Cause	Male Population over 15 years	Clergy- men	Solicitors etc.	Physicians etc.	Teachers	Engin- eers
HEART DISEASES	34.7	46.6	39.9	40.8	42.1	37.4
(Coronary Thrombosis)	15.6	23.1	21.1	24.9	22.5	21.1
MALIGNANT NEOPLASMS	17.1	13.0	15.5	16.2	15.2	18.1
Vascular Lesions affecting the C.N.S.	12.6	16.6	16.5	12.7	14.9	14.6
Bronchitis	4.3	2.1	3.4	1.9	2.7	1.4
Tuberculosis	4.01	-	-	2.9	1.6	3.1
Other Circulatory Diseases	2.7	2.3	4.5	2.9	2.2	2.6
Pneumonia	2.6	1.9	2.2	1.5	1.4	2.3
Hyperplasia of the Prostate	1.5	1.9	-	-	2.2	-
TOTAL DEATHS	145,910	606	526	654	1,029	1,425
CENSUS POPULATION (1951)	1,795,273	5,667	4,033	7,318	16,043	13,035

In most respects this information is closely parallel to the pattern of occupational mortality established twenty years earlier. For instance, the prevalence of tuberculosis continued to decline⁽²⁾ and Scottish clergymen (S.M.R. 34) again had one of the lowest rates of

(1) The proportions of all deaths from major causes have been calculated from data contained in the report of the Registrar General for Scotland (1956), op.cit. For further details refer to Appendix II: Table 2J.

(2) Ibid., p. 32.

TABLE 30 : MORTALITY OF MALES (15 YEARS AND OVER) FROM CERTAIN
MAIN CAUSES FOR SELECTED OCCUPATIONS COMPARED WITH
THAT OF ALL MALES (= 100), 1949-1953⁽¹⁾

OCCUPATION	All T.B.	Cancer Total	Resp.	Vasc. lesions C.N.S.	Cor. Throm.	Other Heart Dis.	Bronch- Pneum.	Acci- dents
ADMINISTRATORS, DIRECTORS, MANAGERS	46	107	95	128	152	119	79	85
COMMERCIAL, FINANCE & INSURANCE	93	106	112	121	141	114	96	81
Proprietors and Managers	91	112	126	130	152	125	103	98
Commercial Travellers	88	118	119	109	140	102	94	84
Salesmen and Shopassistants	97	94	100	105	94	84	87	51
Insurance Brokers & Agents	105	68	(51)	93	130	81	85	(63)
PROFESSIONAL ORDER	65	90	89	111	134	92	59	76
*Ministers, Clergymen, etc.	(34)	71	(48)	105	131	97	50	(49)
Judges and Solicitors	(36)	102	(103)	123	152	90	84	(59)
Physicians and Surgeons	78	101	103	119	173	102	53	119
Teachers	(30)	72	53	96	116	84	47	62
Professional Engineers	63	111	116	119	142	85	58	89
Scientists	(31)	82	(122)	109	100	98	(47)	(67)

(1) Registrar General for Scotland (1956), derived from Table DD,
p. 11b ff.

death from this cause, together with teachers (S.M.R. 30), scientists (S.M.R. 31), and agricultural workers (S.M.R. 39). The report also showed that the incidence of tuberculosis tended to increase in frequency from Class I up to Class V.⁽¹⁾

It seems to be a marked characteristic of the experience of Scottish clergymen that they have had a particularly favourable record in regard to the principal diseases of the respiratory system, as is generally true of the Professional Order as a whole. It is quite clear, for example, that Scottish clergymen have had consistently low rates of death from respiratory tuberculosis, cancer of the respiratory system, bronchitis, pneumonia, and other respiratory diseases.

The incidence of cancer in the experience of Scottish clergymen has been quite remarkable. The Registrar's report noted a rapid increase in the prevalence of malignant neoplasms in the male population: the male death rate from cancer rose from 186 to 240 per 100,000 in the period between 1931 and 1955. The remarkable and apparently inexplicable feature is that, while most occupations cluster around the average,⁽²⁾ Scottish clergymen (S.M.R. 71) have had an unusually low rate of death from cancer, as have insurance agents (S.M.R. 68), draughtsmen (S.M.R. 67), and teachers (S.M.R. 72). Cancer of the respiratory system shows much wider occupational variations, and it is notable that only fishermen (S.M.R. 38) and agricultural occupations (S.M.R. 35) have had lower rates of death from respiratory cancer than Scottish clergymen (S.M.R. 48). Cancer of the respiratory system was also infrequent among teachers (S.M.R. 53), while members of the legal

(1) Registrar General for Scotland (1956), op.cit., p. 68.

(2) Ibid., p. 78.

(S.M.R. 103) and medical professions (S.M.R. 103) were close to average, and scientists (S.M.R. 122) and professional engineers (S.M.R. 116) were in excess of expectations.

The incidence of accidental deaths also showed marked occupational variations and appeared to be highest in Social Classes I and V. However, accidental deaths were generally low throughout the Professional Order (S.M.R. 79) and this is most true of clergymen (S.M.R. 49), judges and solicitors (S.M.R. 59), teachers (S.M.R. 62), and scientists (S.M.R. 67). By contrast, physicians and surgeons (S.M.R. 119) had an excessive rate of accidental deaths, especially from accidents in the home.

The rate of death by suicide in the male population for this five year period was 5 per 100,000. The experience of clergymen was again close to expectations, while members of the legal and medical professions exceeded expectations. But the total number of deaths was again too few to arrive at reliable estimates.

Scottish clergymen also experienced possibly excessive deaths from diabetes mellitus (6 actual deaths as to 2 expected), as did teachers (12 actual as to 5 expected deaths), and it appears that they also experienced excessive deaths from diseases of the digestive system, as did teachers, engineers, and physicians and surgeons.

The really significant aspect of this report, however, is the prevalence and distribution of coronary heart disease, which has special relevance when one considers the experience of Scottish clergymen. The incidence of all forms of heart disease increased very significantly between 1931 and 1955, and by 1955, as we have seen, was responsible for approximately one third of all deaths and it has remained at that level ever since. This phenomenon has been observed

in most Western societies, almost without exception. A similar increase has been observed in the incidence of cancer, which has shown a standardized increase of 41 per cent for males between 1931 and 1966⁽¹⁾ and which now accounts for approximately one quarter of all deaths in the male population. Between them heart diseases and cancer pose two major problems for contemporary medical research.

Among the various forms of heart disease, the greatest single increase, especially for males, has been in the incidence of coronary heart disease.⁽²⁾ The Registrar offered an analysis of the incidence of coronary heart disease according to Social Classes, as had been done by the Registrar General for England and Wales in 1931,⁽³⁾ and it was found to be most prevalent in Social Class I and then fell progressively to be least prevalent in Class V.⁽⁴⁾ By contrast, other forms of heart disease showed little variation according to Social Class and did not reveal any significant occupational variations. Of the occupational Orders, the Professional Order (S.M.R. 134) had one of the highest rates of death from coronary thrombosis, although it was even more common in Commercial (S.M.R. 141) and Administrative Orders (S.M.R. 152).

It is evident from this data that coronary heart disease has been the only major cause of death for which the experience of Scottish clergymen has been significantly in excess of expectations, at least up to the early 1950s. In 1949-53, for all ages over 15 years, the

(1) Annual Report of the Registrar General for Scotland, 1966 (H.M.S.O. 1967), p. 30 f.

(2) Registrar General for Scotland (1956), op.cit., p. 81.

(3) Registrar General for England and Wales (1938), op.cit.

(4) Registrar General for Scotland (1956), op.cit., p. 81.

frequency of deaths from coronary heart disease among Scottish clergymen (S.M.R. 131) was close to the Professional average (S.M.R. 134) and significantly in excess of the male average. On the other hand, it can be seen that the frequency of other forms of heart disease among Scottish clergymen (S.M.R. 97) was close to average. Moreover, although vascular lesions affecting the Central Nervous System were the second greatest cause of death in this group (16.6% of all deaths) it was in fact no more frequent (S.M.R. 105) than one would expect of the male population.

A comparison of the English and Scottish data concerning the incidence of coronary heart disease in the Professional Order in 1931 and 1951 reveals some relevant facts.

TABLE 31 : CORONARY HEART DISEASE IN THE PROFESSIONAL ORDER,
ENGLAND-WALES AND SCOTLAND, 1931-32 AND 1949-53

OCCUPATION	ENGLAND-WALES		SCOTLAND	
	1930-32 20-65 years	1949-53 20-64 years	1949-53 15-64 years.	All ages over 15 years
Anglican Clergy	218	153	152	131
Other Ministers	211	130		
Catholic Religious	(-)	193		
Medical Practitioners, etc.	368	159	158	173
Judges, Barristers, etc.	227	121	156	152
Teachers	143	107	90	116
Professional Engineers	154	116	129	142
Scientists	-	100	84	100
PROFESSIONAL ORDER	224	147	116	134

In the first place, it should be noted that the lower occupational mortality ratios in the later period are not necessarily indicative of

a reduction in the frequency of coronary disease among these selected professions. In some cases it may be, but that cannot be established from mortality ratios which are a relative measure. As coronary disease had become more common as a cause of death for the male population so one would expect occupational mortality ratios to be nearer the average.

Secondly, it is evident that coronary heart disease has been a major threat to the health of British clergymen throughout this period. This has been most true of Anglican clergy and, more recently, of Catholic Religious in England and Wales. In the case of Scottish clergymen, it is apparent that coronary disease is not notably excessive in the working years up to 65 years of age but it is equally evident that it increases significantly beyond 65 years of age. Moreover, if the English data can be taken as a guide, it would seem that this is not a recent phenomenon and this would further suggest that the recent claim that more Church of Scotland ministers have been dying from coronary thrombosis⁽¹⁾ is questionable. According to the information of these reports, British clergymen have been vulnerable to coronary disease for some time; although there is admittedly less evidence to show that this has been true of Church of Scotland ministers in particular. Whether or not this claim has substance remains to be seen.

Thirdly, the seriousness of this situation should not be exaggerated. In comparative terms, it is evident that coronary disease has been much more of a threat in some other occupational groups than it has been to Scottish clergymen. For example, in Scotland in 1949-53, a number of occupations, including physicians and surgeons (S.M.R. 173);

(1) As in the petition to the General Assembly in 1969 referred to in Chapter 2, q.v.

administrators and directors (S.M.R. 152), proprietors and managers (S.M.R. 152), judges and solicitors (S.M.R. 152), professional engineers (S.M.R. 142), and commercial travellers (S.M.R. 140), had rates of death from coronary disease considerably in excess of Scottish clergymen (S.M.R. 131). Attention has been drawn to the fact that, for the working years of 15-64 years, in 1949-53 Scottish Clergymen (S.M.R. 106), together with scientists (S.M.R. 84), teachers (S.M.R. 90), local authority officials (S.M.R. 100), and professional engineers (S.M.R. 129), were among the occupations in Social Classes I and II to have relatively low rates of death from coronary disease.⁽¹⁾

Nevertheless, in view of the fact that this is the only respect in which the experience of Scottish clergymen is notably unfavourable, this phenomenon warrants closer examination.

(iii) CHURCH OF SCOTLAND CLERGY DECEASED UNDER 70 YEARS,
1958-1967

It has been possible to complement the Registrar General's reports with more recent information about the causes of death of Church of Scotland ministers. The author was given access to the death certificates of all Church of Scotland ministers who died under 70 years of age in the period 1958-1967.⁽²⁾ In general, an examination of this information confirms the pattern established by the Registrar General's reports, but there is also evidence of what may be a significant change in the mortality experience of Church of Scotland ministers.

(1) S.L. Morrison (1957), *op.cit.*

(2) The author gratefully acknowledges the valuable co-operation and assistance which he received from the staff of the Register House, Edinburgh, in examining these records. At the time, only the death records and certificates up to December 31st, 1967 were complete. These records also only apply to ministers who died in Scotland.

In these ten years, 1958-1967, a total of 213 Church of Scotland ministers died under 70 years of age, which represents 33.3 per cent of all deaths in this time. Like the long-term survivors, the experience of this group is of particular interest, although for different reasons.

TABLE 32 CHURCH OF SCOTLAND CLERGY DECEASED UNDER 70 YEARS,
1958-1967

Period	Total	% of Total Deaths
1958-1962	106	31.54
1963-1967	107	35.19
TOTAL		
1958-1967	213	33.36

As was demonstrated earlier, an increasing proportion of the Kirk's ministers have been dying at younger ages, and this development has been evident since the mid-1950s and has become most apparent since 1966. As a proportion of the total deaths, the number of ministers dying under 70 years increased between 1958 and 1967, from 31.5% in the first quinquennium up to 35.1% of all deaths in the second quinquennial period. This is not a dramatic increase and may simply be relative to the age distribution of the total population. But it is an outstanding fact that deaths under 70 years during 1967 were as high as 50.81% of all deaths; that is to say, one half of those who died in 1967 were under 70 years of age.⁽¹⁾

(1) Refer to Appendix II: Table 2D.

Whether or not this is indicative of an increasing death rate in the younger age groups cannot be established with certainty. It is a fact, however, that each of these 213 men died before reaching the official retiring age and were lost to the active ministry as a direct result of fatal illnesses. Their experience, therefore, is of particular relevance in studying the health of Church of Scotland ministers.

As is typical of this clergy group, the vast majority of these men were married. This applied to 191 (i.e. 89.7%): 10 of these had been married twice, seven were widowers, and one was divorced. Only 22 (i.e. 10.3%) were single, which is slightly below the 1951 Census figure for Church of Scotland ministers.

Most of these men, 115 (i.e. 79.3%), had been ordained to the ministry of the Church of Scotland between 25 and 34 years, which is also consistent with the usual experience of this clergy group. However, an unusual number of them had been late-entrants to the ministry: 24 (i.e. 11.2%) had been ordained over 40 years of age, and in seven cases they had been more than 50 years of age at their ordination. By comparison, only 5.4% of the long-term survivors had entered the ministry after 40 years of age.

It has been possible to establish few details of their occupational experience. It is noteworthy, however, that they were generally more mobile than their colleagues who survived 85 years of age. This is particularly true when it is considered that none of them, except possibly the 60 who died between 65-69 years, completed a full-term in the ministry. A total of 49 (i.e. 27.8%) had served in four or more parishes compared with 22.5% of those who died in excess of 85 years,

while 23 or 10.7% had held only one parish compared with 17.1% of the long-term survivors. A larger proportion of these ministers had also held parishes in Scotland's four main cities (Glasgow, Edinburgh, Dundee and Aberdeen) and in the large burghs around the Glasgow conurbation. It may also be noted that only 10 of these men, less than 5%, held non-parochial appointments, including 2 in academic positions, 2 in administrative offices, 5 special chaplaincies, and one full-time Presbytery Clerk.

A number, 42 in all, had in fact withdrawn from the ministry prior to their deaths. Most of these had done so as a result of early disablement.

These are simply a few incidental pieces of background information and it can be seen that in some respects their experience varies from that of their colleagues who have survived 85 years. However, we are chiefly concerned with the causes of their deaths as this compares with the earlier data provided by the Registrar General. The causes of death of all these Church of Scotland ministers who died in Scotland under 70 years of age in the period 1958-1967 are fully detailed in Table 33 (over).⁽¹⁾ Of the 213 cases, 15 in all have been recorded as being "ill-defined or unknown", and 11 of these had died outside Scotland.

The principal causes of death are quite outstanding. It can readily be seen that all forms of heart disease have been the greatest cause of death, being responsible for the death of 112 of these men. Heart diseases are then followed by malignant neoplasms (36 cases) and vascular lesions affecting the Central Nervous System (15 cases) as the major causes of death for this group.

(1) Causes of death have been classified in the following table according to the World Health Organisation, Manual of the International Classification of Diseases, Injuries and Causes of Death, 1955 Revision (Geneva, 1957).

TABLE 33. CAUSES OF DEATH CHURCH OF SCOTLAND: CLERGY DECEASED
UNDER 70 YEARS AGE, 1958 - 1967.

CAUSE	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967	TOTAL
001-019 T.B.	1										1
140-205 MALIGNANT NEOPLASMS	3	6	3	3	7	1	1	6	2	4	36
260 DIABETES											-
330-334 LESIONS AFFECTING CNS.	5			1	1	1	1		1	5	15
340-357 Other DISEASES OF CNS.	1							1			2
410-443 HEART DISEASES	13	12	9	8	10	11	10	9	13	17	112
420 CORONARY THROMBOSIS	9	8	9	6	8	9	7	5	7	10	78
421-422 MYOCARDIAL INFARCTION		3		1		1		2	2	1	10
420-44 Other Heart Diseases	2	1			2		3	2	4	5	19
440-449 HYPERTENSIVE H/D.	2			1		1				1	5
444-447 HYPERTENSION Without H/D				1	1			1			3
450-46 General ARTERIO-SCLEROSIS	1			1							2
490 PNEUMONIA				1			1	2	1	1	6
500-502 BRONCHITIS	1	1		1							3
510-517 Other RESPIRATORY DIS.		1	1				1				3
520-525 GASTRIC ULCER			1								1
530-538 Other DIGESTIVE DIS.						1	1			1	3
540-547 Diseases of LIVER										1	1
550-569 Other DIS. GENITO-URINARY S.					1			1			2
720-749 Diseases ref. to Systems or Organs	1			1				1			3
750-95 Ill. Defined or UNKNOWN	1	1	3		2	1	3	1	1	2	15
SUICIDE			1			1			1		3
ACCIDENTS & OTHER VIOLENCE				1					1		2
TOTALS	27	21	18	18	22	16	18	22	20	31	213

Closer examination of the experience of this group by comparison with earlier information reveals a number of significant facts (Table 34, following).

TABLE 34 : PROPORTION OF DEATHS FROM MAIN CAUSES FOR CHURCH OF SCOTLAND MINISTERS DECEASED UNDER 70 YEARS AGE, 1958-67

CAUSES	CHURCH OF SCOTLAND			Scottish Clergy	Scottish Males
	1958-62	1963-67	Total	1949-53	1967
TOTAL ALL CAUSES	106	107	213	606	-
Diseases of the Circulatory System	52.8	57.0	54.9	-	-
Heart Diseases	49.05	56.07	52.5	46.6	33.97
Coronary Heart Disease	37.7	35.5	36.6	23.1	-
Malignant Neoplasms	20.7	13.08	16.9	13.09	20.39
Vascular lesions affecting the C.N.S.	6.6	7.4	7.04	16.6	16.7
Diseases of the Respiratory System	5.6	5.6	5.6	5.1	-
Bronchitis- Pneumonia	3.7	4.6	4.2	4.0	5.99
Diseases of the Digestive System	0.94	3.7	2.3	2.3	-

Firstly, it can be seen that all forms of heart disease have been the greatest cause of death in this group, being responsible for more than one half of all the deaths recorded. In general this is consistent with earlier information. However, these figures do suggest a possible increase in the total proportion of deaths due to all heart diseases, which seems to have been progressive. The proportion of deaths due to

heart diseases among Scottish clergymen was 46.6% in 1949-53. By comparison, among Church of Scotland ministers deceased under 70 years deaths attributed to heart diseases increased from 49.05% in 1958-62 up to 56.07% in 1963-67. It can be observed, moreover, that this is considerably in excess of the male population, for whom heart diseases have been responsible for one third of all deaths in recent years.

The most outstanding aspect of this data concerns the incidence of coronary heart disease. It has been established that coronary disease has constituted the greatest threat to the well-being of Scottish clergymen up to the early 1950s, an experience almost certainly shared by Church of Scotland ministers. In recent times it has been claimed that more of the Kirk's ministers have been dying from coronary disease, and, to some extent, this claim is supported by this recent information. In 1949-53 the proportion of deaths among Scottish clergymen attributed to coronary disease was 23.1% and was the greatest single cause of death. Of the Church of Scotland ministers who died under 70 years of age in 1958-67 more than one third (36.6%) died from coronary disease, an increase of more than ten per cent for all deaths. This would suggest a significant increase, but it is not absolutely conclusive. It must be remembered that the earlier information refers to all Scottish clergymen deceased at all ages while the later information only concerns Church of Scotland ministers deceased under 70 years age. The contrast in their experience is quite apparent, but should not be exaggerated. Moreover, while it is evident that coronary disease has been the greatest cause of death among Church of Scotland ministers and while the proportion of deaths due to this disease has probably increased, it can also be observed that its incidence has not increased since 1958. If anything, the proportion of deaths from coronary disease has shown a marginal decrease over

this period: from 37.7% of all deaths in 1958-62 down to 35.5% in 1963-67. However, it is quite clear that coronary heart disease has continued to be a major threat to the health of Church of Scotland ministers.

Malignant neoplasms, thirdly, have been the second greatest cause of death among Church of Scotland ministers deceased under 70 years. It would seem that a higher proportion of deaths were caused by all forms of cancer between 1958-62 than had been previously true. But over the whole period, 1958-67, the proportion of deaths due to cancer was lower than could be expected: 16.9% for Church of Scotland clergy under 70 years compared with 20.3% for the male population. This is consistent with earlier information, although it appears that there may have been a slight increase in deaths from cancer among Church of Scotland ministers.

Vascular lesions affecting the Central Nervous System have been the third greatest cause of death in this group, but have been responsible for a much lower proportion of deaths than previously recorded. The proportion of deaths from this group of diseases has been very considerably less among Church of Scotland ministers under 70 years (7.04%) than among Scottish clergymen (16.6%) and Scottish males (16.7%). This contrast is almost certainly due to the fact that vascular lesions affecting the Central Nervous System increase with age and cause a much higher proportion of deaths in older age groups, especially over 70 years of age.

Deaths from diseases of the respiratory system, particularly from bronchitis and pneumonia, have been consistently low among Scottish clergymen and this applies to those Church of Scotland clergy deceased under 70 years in recent years. On the other hand, however, there is some indication that deaths from diseases of the digestive system may

have increased slightly in the age group under 70 years. This possibility should not be over-emphasized as the proportion of deaths from these diseases in this group over the entire period is consistent with the experience of all Scottish clergymen in the earlier data.

It can be seen, therefore, that the only significant variation from the earlier evidence provided by the Registrar General has been a marked increase in the proportion of deaths among Church of Scotland ministers due to all forms of heart disease. It appears that such deaths have probably increased progressively over the last two decades and that heart diseases are now responsible for more than one half of all deaths of Church of Scotland ministers under 70 years of age. Coronary heart disease, in particular, has been responsible for more than one third of all deaths in this group up to the age of 70 years and this appears to indicate an increase in deaths from coronary disease among Church of Scotland ministers. In other respects the experience of this group has been consistent with earlier evidence.

Four general conclusions may be drawn from an examination of the causes of death in the experience of Church of Scotland ministers between 1930 and 1969.

In the first place, heart diseases have been the greatest cause of death for this clergy group and for Scottish clergymen in general and the proportion of deaths from all forms of heart disease has increased progressively over this period. In fact, heart diseases were responsible for more than one half of all deaths among Church of Scotland ministers under 70 years from 1958-67. Deaths from all forms of heart disease have also increased progressively in the Scottish male population and now contribute to one third of all deaths.

It is evident, secondly, that the excess of deaths from heart diseases among Church of Scotland ministers has been almost entirely

due to the prevalence of coronary heart disease. Indeed, as has been stressed throughout this report, this is the only respect in which their experience has been notably unfavourable by comparison with the male population and with other occupational groups. On the basis of the experience of those ministers who have died under 70 years in the ten years 1958-67, moreover, there is evidence that there may have been an increase in the proportion of deaths due to coronary disease. Up to the early 1950s, deaths from coronary disease were most excessive in the older age groups, over 65 years. However, the most recent evidence indicates that deaths from coronary disease have probably increased among Church of Scotland ministers in the younger age groups. Of the 78 fatal coronaries recorded among Church of Scotland ministers deceased under 70 years from 1958 to 1967 a total of 60 (i.e. 76.9%) were suffered by men under 65 years of age, and several were in their 40s. This development must be regarded as a cause for concern.

Although the importance of this phenomenon cannot be under-rated, it should not be exaggerated. It is seen in perspective when it is remembered that coronary disease has been much more excessive among other occupations in the Professional and Commercial Orders in Scotland. This has been most true of the medical and legal professions and of top-level administrative and managerial occupations. By comparison with these occupational groups, the experience of Church of Scotland ministers has not been so alarming as appears on the surface. Nevertheless, this phenomenon cannot be ignored and some of its implications will be considered in the following chapter.

The third feature to emerge from the available information is that the prevalence of most other major causes of death among Church of Scotland ministers has been close to expectations for the male population. This applies to vascular lesions affecting the Central

Nervous System, other forms of heart disease (e.g. myocardial degeneration, valvular heart diseases, and hypertensive heart disease), and other diseases of the circulatory system (e.g. hypertensive disease and general arteriosclerosis). Each of these categories have been major causes of death, especially in older age groups, but have not been particularly excessive. From the limited information available, it would also appear that deaths by suicide, those resulting from accidents, and those from diseases of the digestive system have been close to expectations.

The fourth and most positive conclusion is that Church of Scotland ministers have experienced unusually low rates of death from all other major causes. This has been most outstanding in the case of diseases affecting the respiratory system, including pulmonary tuberculosis, cancer of the respiratory system, bronchitis and pneumonia. It has also been apparent, though to a lesser extent, in the case of malignant neoplasms. This is an inexplicable phenomenon, although it is obviously related to their very low rate of death from cancer of the respiratory system in particular. Their low rate of death from respiratory diseases is typical of the Professional Order as a whole, but the record of Scottish ministers is quite outstanding in this respect and is matched only by that of teachers among the professions. It is also apparent that deaths from infectious and parasitic diseases have been almost non-existent among Scottish clergymen throughout this period. It seems not unlikely that these phenomena are possibly related to the observance of healthy personal habits and standards of hygiene, although it may also be true that both their standard of living and the conditions of their work have contributed to this positive record.

5. SEASONAL INCIDENCE OF DEATH

The seasonal incidence of death of Church of Scotland ministers

from 1950 to 1969 is detailed in Table 35, following and yields no significant or unusual information. Generally speaking, it has been consistent with the seasonal variations evident in Scottish mortality data. The highest rate of death, as is true for the Scottish population, has occurred in the first quarter of the year (Jan./March) during the winter months, as one would expect. The death rate has been lowest in the third quarter (July/Sept.) during spring and early autumn. For individual months, most deaths have occurred during December and the least in June. Comparatively few deaths have occurred throughout summer, from June to August.

6. REGIONAL INCIDENCE OF DEATH

Scottish demographic data and vital statistics reveal significant regional variations in the rate and causes of death. There is no doubt that local environmental conditions usually exert an appreciable influence on mortality experience and affect the health of the local population. According to recent information,⁽¹⁾ for example, the highest death rate in Scotland occurs in the large cities and burghs and then follows a declining gradient down to small burghs and towns, with the lowest rate of death in rural, landward areas. The highest rate of death for the cities and large burghs has been recorded in Port Glasgow, with the lowest in East Kilbride. The rate of death for individual counties has been highest in Bute and the lowest in Caithness. In general, the mortality experience of the sparsely populated rural areas is more favourable than that of the densely populated, industrialized urban areas.

With respect to the health of Church of Scotland ministers, a regional analysis of mortality is not possible. Church of Scotland ministers as a group are highly mobile and tend to lead a migratory

(1) Annual Report of the Registrar General for Scotland, 1967 (H.M.S.O., 1968), p. 78.

TABLE 35 : MORTALITY EXPERIENCE OF CHURCH OF SCOTLAND CLERGY:
SEASONAL INCIDENCE OF DEATH, 1950-1969

Period	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
1950/54	38	41	31	34	43	34	27	35	33	25	33	42	416
1955/59	37	36	32	25	35	20	19	20	19	32	24	43	342
1960/64	36	34	28	28	27	20	25	22	21	20	22	42	325
1965/69	27	26	18	21	32	19	24	19	27	23	20	26	282
Monthly Totals	138	137	109	108	137	93	95	96	100	100	99	153	1365
Quarterly Totals	384				338			291				352	

existence.⁽¹⁾ It is likely that this fact is relevant to their experience of health, but it reduces the significance of regional variations in mortality as far as their health is concerned. In any event, the extent and frequency of their occupational and geographical mobility makes it almost impossible to establish reliable regional variations in the pattern of mortality. Ministers tend to change parishes every seven years on average and during their ministries may hold parishes as far removed as the Outer Hebrides and the Glasgow conurbation, experiencing a variety of environmental conditions in their working life-time. However, two relevant facts have come to our attention in the preceding discussion.

In discussing the experience of ministers who have achieved notable longevity, it was observed that those ministers who have exceeded 85 years of age have generally led more settled lives than is usually true of Church of Scotland ministers. They had certainly been less mobile than is typical of this clergy group and the majority of them, many of whom had continued their active ministries well beyond the usual forty year period, had held three or fewer parishes. Moreover, it was noted that most of these had spent more than twenty years in a small country town or rural area. There have been examples of ministers occupying as many as five or six parishes and of others who have spent long periods in urban parishes who have nevertheless achieved notable longevity; but they are exceptions.

On the other hand, it has been noted that the experience of ministers who have died under 70 years of age has contrasted with that of their long-living colleagues in both respects. In the case of early death, as we have seen, ministers have tended to be more mobile than the long-term survivors. A large proportion of those who died under 70 years had

(1) q.v. Part II: Chapter 5.

also been engaged in parishes in Scotland's major cities and large burghs, especially in parishes in the Glasgow conurbation and the surrounding burghs. However, neither of these factors, locale and mobility, appears to be particularly significant in instances of early death when compared with the average experience of Church of Scotland ministers.

No clear correlation can be established between early death and either parish locale or occupational mobility without more precise information. It seems likely that mobility and local environment do affect the health of ministers, but the exact nature and extent of that influence is indeterminable and no generalizations can be postulated with any real confidence.

7. MORTALITY ACCORDING TO TYPES OF MINISTRY

A comparison of the mortality experience of different types of ministry in the Church of Scotland, comparing the experience of parish ministers with that of 'specialist' ministers, cannot be made with any reliability. The total population involved in non-parochial ministries is too small to be statistically manageable or reliable. Furthermore, no clear-cut distinction can be made between spheres of ministry. Ministers of the Church of Scotland constitute a 'floating' population and there are frequent movements between the various types of ministry conducted by the Church of Scotland: most of those in non-parochial positions, with very few exceptions, began their careers within the parish ministry, while a significant number of parish ministers have had experience in a non-parochial appointment at one time or another. Moreover, the conditions experienced by some special groups, such as ordained Overseas Missionaries, are so far removed from those to which parish ministers experience that they could be the subject of detailed examination in themselves.

The only generalization which can be made from the evidence presented to this stage is that few of those engaged in non-parochial appointments have achieved notable longevity and equally few have been victims of early death. In the last two decades, only 4 (i.e. 3.6%) of those ministers who survived 85 years and only 10 (i.e. 4.6%) of those who have died under 70 years had been actively engaged in non-parochial appointments immediately prior to their retirement or death. In very general terms this would suggest that the mortality experience of those involved in non-parochial ministries (who have comprised in the vicinity of 10-12% of the total population) is consistent with that of Church of Scotland ministers in general. However, that cannot be established with absolute certainty.

CONCLUSION

In considering particular details of the mortality experience of Church of Scotland ministers it is all too easy to lose sight of the total pattern which emerges from the particulars. Some details, when considered in isolation, may appear to be disturbing or even alarming. However, statistical minutia should be viewed in the context of the total pattern and when all the evidence, from a variety of sources and over a forty year period, is considered as a whole then the overall pattern is very favourable. In the light of available mortality data, it can be concluded that the reputation of Church of Scotland ministers for notable longevity and a relatively high standard of health is justified, and it would appear that this favourable record was sustained certainly up to the early 1950s. All the evidence confirms this conclusion.

There can be no doubt that Church of Scotland ministers generally experience greater average length of life than is true of the Scottish male population and most other professional groups. In terms of death

rates, it would appear that the health record of Church of Scotland ministers has been particularly sound up to the age of 45 years and no evidence has emerged to suggest that this has changed in any way. It has also been established that this clergy group has experienced unusually low rates of death from most of the principal causes of death by comparison with the male population and with other professions. This has been most outstanding in the case of diseases affecting the respiratory system, including bronchitis, pneumonia, pulmonary T.B., and cancer of the respiratory system, and has been true to a lesser extent of all forms of cancer. In general, then, Church of Scotland ministers have been among the healthiest occupational groups in Scotland as far as this can be evaluated from mortality data. The only professional group to match and in some respects to exceed their experience have been teachers, whose mortality experience has been closely parallel to that of Church of Scotland ministers.

Against this positive background, the only negative aspect of the mortality experience of Church of Scotland ministers up to the early 1950s has been their vulnerability to coronary heart disease. This is the only respect in which their experience has been significantly unfavourable by comparison with Scottish males in general. However, coronary disease has been an even more serious threat to the health of those occupied in the medical, legal, and engineering professions. It is also apparent that the excessive deaths from coronary disease among Church of Scotland clergymen up to the 1949-1953 period occurred in the age groups over 65 years.

However, there is some evidence to suggest that the health of Church of Scotland clergy, as a group, has deteriorated in the 1953-1969 period. It has been noted, for example, that the average age of death of this group has declined appreciably since 1960. In itself,

average age of death is an unreliable measure and is far from conclusive. But it is corroborated by more convincing evidence of a decline. The actuary of the Kirk's pension fund observed a significant excess of deaths in the 65-74 age group between 1953 and 1962. Deaths in this age group were not so excessive from 1963 to 1967, but the actuary's information did reveal an increase of mortality in younger age groups, especially in the 50-64 age range. There is irrefutable evidence that more ministers have been dying in the 50-64 age group ever since 1963, and there is some indication that this phenomenon may have accelerated in the last three years. There is clear evidence, moreover, that deaths from coronary heart disease have increased substantially, particularly under the age of 65 years. Between 1958-67 more than one third of those ministers who died under 70 years of age were victims of coronary disease.

The signs of declining health among Church of Scotland ministers between 1953 and 1969 are unmistakable, that is, in so far as mortality data is indicative of a group's health. There is, however, a real danger of over-stating the seriousness of these developments. The true position can only be seen in perspective when considered in relation to the experience of Scottish males and of other occupational groups. Despite these indications of an overall decline and although their advantage has been reduced, Church of Scotland ministers are still a relatively healthy group by comparison with the male population in general and with most other professional groups. Most ministers could expect to live beyond the average length of life, although their expectation above the age of 45 years is close to average. Also, although they are particularly susceptible to coronary disease, ministers are significantly less vulnerable to all other major causes of death, especially respiratory

diseases, than is generally true of Scottish males.

We now turn our attention to the morbidity experience of Church of Scotland ministers in order to complement and to supplement the mortality data presented here.

CHAPTER 10

MORBIDITY EXPERIENCE

INTRODUCTION

Morbidity is another valuable indicator of the health of a community or group and may reveal aspects of a group's experience of health and illness which do not appear in mortality data. Morbidity applies to any experiences of illness, disease, or disablement which render members of a group temporarily or permanently inactive. In considering the morbidity experience of Church of Scotland ministers we will be chiefly concerned with the extent to which these ministers suffer from crippling illnesses and disorders as distinct from fatal diseases. None of the mortality information examined in the preceding chapter discloses any facts about the frequency with which these clergymen may be disabled or with which they suffer from chronic, incapacitating illnesses. Nor does it indicate how often, for how long, or from what causes these ministers are hospitalized or bed-ridden. It is to this aspect of their experience that we now turn.

From the available mortality data it has been concluded that Church of Scotland ministers generally enjoy a relatively high standard of health. One could reasonably expect that their morbidity experience would be consistent with this general conclusion. That, however, cannot be assumed, especially in view of the fact that their mortality experience suggests a recent decline in the overall health of this group. It is conceivable, for instance, that a significant number in any occupational group could be disabled or suffer from chronic diseases without this affecting the death rate of the entire group.

However, there are difficulties in undertaking an occupational morbidity study. For one thing, little comparative data is available

on the incidence of morbidity among particular occupational groups. No adequate basis for comparison is available and, therefore, morbidity studies are usually descriptive in nature.

Secondly, no systematic or standardized classification of morbid conditions has been generally accepted. Morbidity, as a general expression, represents a broad continuum, ranging from a common cold to hemiplegia resulting from a massive stroke, including conditions as far removed as rheumatoid-arthritis and schizophrenia. Death is an absolute event, but this is not the case with morbid conditions. The basic problem is to establish criteria by which morbidity may be identified and evaluated. One suggestion, referred to earlier, is that a morbid condition is present when either a person becomes conscious of symptoms or of some disability or when someone else, suitably qualified, decides that disease is present.⁽¹⁾ The same author suggested that morbid conditions could be classified according to severity: according to whether a condition is serious, moderate or mild, minor, or ill-defined.⁽²⁾ However, the issue is complex and no standardization of morbidity has been generally established for research purposes.

The following report is devoted to only one category of morbidity as it affects Church of Scotland ministers. It refers to those cases in which ministers have been permanently disabled and rendered incapable of fulfilling their occupational functions as a direct result of illness, disease, or injury. It is confined to the most serious forms of morbidity and no attempt is made to establish the

(1) P. Stocks (1949), op.cit.

(2) Ibid. (Also refer to Chapter 8, q.v.).

frequency or causes of hospitalization,⁽¹⁾ nor is any attempt made to discover the extent to which morbidity contributes to ministers resigning, becoming unattached or seeking leave of absence from the active ministry. The following discussion is concerned solely with those cases in which ministers have been permanently incapacitated before attaining retiral age between 1950 and 1968.

1. SOURCE OF INFORMATION

The Church of Scotland's Aged and Infirm Ministers' Fund makes special provision for the early retirement of ministers who have been incapacitated by illness, disease, or injury. This is carried out through a special fund for Early Disablement. Two categories of men are entitled to benefit under these regulations.⁽²⁾ Ministers who have served a minimum period in the continuous service of the Church of Scotland and who have attained the age of 65 years are enabled to retire due to "infirmity" if illness makes it impossible for them to continue in the active ministry. The second are those who are enabled to retire due to "early disablement", irrespective of their age or years of service, if it is clearly established that they have been permanently incapacitated. Both virtually amount to the same thing. The only real distinction is technical in that the payable annuity is determined according to a particular individual's years of service in the Church of Scotland.

In either case, the application for retirement benefits is supported by a medical certificate which establishes, on medical evidence, that the individual minister has been disabled and his

(1) Meiburg and Young (1958), op.cit., conducted a valuable study of hospitalized ministers in the U.S.A. Most of their 113 cases were Baptist pastors (see Appendix I: Table 1A). However, their study is not strictly comparable with the report presented here.

(2) The complete regulations may be found in Reports to the General Assembly, 1968, p. 231 ff.

infirmities render him incapable of working. If such a minister is subsequently employed, within or without the Church, the annuity is suspended for the duration of that employment and his case may be subject to review.

The facts reported here concern all cases of retirement due to infirmity and early disablement which were officially accepted by the Aged and Infirm Ministers' Fund Committee between January 1950 and December 1968. The information was collected by the author with the permission and under the supervision of the Secretary of the Church and Ministry Department.⁽¹⁾ In view of the confidential nature of the information, strict precautions have been taken to ensure the anonymity of the individual ministers involved. No identifiable personal data has been recorded or reported.⁽²⁾

2. THE INCIDENCE OF DISABLEMENT, 1950-1968

Between January 1950 and December 1968, a total of 217 cases of retirement due to infirmity or early disablement were accepted by the Aged and Infirm Ministers' Fund Committee. In each case, the existence of incapacitating illness was medically attested.

At a conservative estimate these cases represent approximately 6 per cent (217:3580) of the total population at risk. The proportion lost from the active ministry as a result of incapacitating illness, disease, and injury would be greater if allowance were made for those

- (1) The author received very valuable assistance and support from Rev. Karl Greenlaw at a number of points throughout the conduct of this project, and his aid is gratefully acknowledged.
- (2) The basic data in individual cases included: year of birth, age and year of ordination, marital status and family, number of charges held, age retired, and the medical diagnosis. No names of persons or places were provided and this confidentiality has been carefully protected.

ministers who were over 70 years of age at January 1950. It should also be borne in mind that these figures only refer to those ministers officially enabled to retire due to early disablement. They provide no information about other forms of morbidity. For instance, the frequency with which illness among these ministers leads to hospitalization, extended leave of absence, unattachment, or resignation is an unknown quantity. Over this period, 1950-1968, there has been an annual average of just below 12 cases of disablement.

(i) AGE. The incidence of disablement in the Church of Scotland ministry, predictably, increases with age and 60.4 per cent (132: 217) of these men were aged 65-69 years at the time of their retirement (see Table 36, following). The total number of cases of disablement has been falling steadily, but that has no special significance since the total population at risk has been steadily reduced in the same period.⁽¹⁾ What may be significant is that the age at which disablement occurs has been changing, particularly since 1960. On the surface, it would appear that ministers of the Church of Scotland have been incapacitated at progressively younger ages through the last two decades.

TABLE 36 : AGE AT DISABLEMENT

Year	Total	-45	45/49	50/54	55/59	60/64	65/69	Unknown
1950-54	66	-	-	3	4	21	38	-
1955-59	61	-	-	-	4	13	44	-
1960-64	48	4	2	3	4	7	27	1
1965-68	42	2	1	2	4	10	23	-
TOTALS	217	6	3	8	16	51	132	1

(1) Refer to Appendix II: Table 2A for details of the Church of Scotland's ministerial manpower. Also refer to Chapter 5, q.v.

It is most noticeable that the majority of those disabled under 60 years of age (22:33) and all of those disabled under 50 years of age have occurred since 1960. This change has taken place in spite of the fact that the average age of the ministry has been rising and despite the fact that proportionately fewer young men have entered the ministry in the same period.

This does not necessarily mean that the risk of disablement has been increasing in younger age groups, but it does seem highly probable. The retirement of these younger men may simply reflect changing attitudes and greater sympathy toward early disablement. But there is a real possibility that it is a manifestation of a declining standard of health in the Church of Scotland ministry, which would be consistent with indications of an increasing death rate in the younger age groups. In any event, it is quite clear that the risk of disablement increases with age and is greatest for ages over 60 years, as one would expect.

(ii) MARRIAGE AND FAMILY. With regard to marital status, 188 of these men were married (87.4%), as is typical of the Church of Scotland ministry. Of these, three were widowers at the time of their retirement, eleven had been married twice, and one three times. None of these men had been divorced. This group appears to include an unusually low proportion of bachelors; little more than 12 per cent as against 25 per cent in the total population of Church of Scotland ministers at the 1951 Census.

In the cases of the married men, most had families, ranging from one to six children. The majority (47 per cent) had between two and four children. However, in a large proportion of these cases (17 per cent) no children had issued from the marriage.

(iii) OCCUPATIONAL HISTORY. It is of particular interest to note that all of these 217 men, with only one exception, were actively involved in the parish ministry at the time of their disablement. Some had previous experience in non-parochial ministries, especially as Overseas Missionaries or in Chaplaincies, but had subsequently entered the parish ministry. It seems unusual that cases of disablement have been almost non-existent among those who have specialized in non-parochial forms of ministry.

More than one half of these men, not surprisingly, had been ordained in the 1920-1939 period. Of those ordained prior to the union in 1929, 46.6 per cent had been ministers of the United Free Church which is identical to the proportion of United Free Church ministers who entered into the union.

It was observed earlier that an unusually high proportion of those ministers who have died under 70 years of age were late entrants to the ministry.⁽¹⁾ The same does not apply in the cases of disablement. Most of these men, in common with the general experience of Church of Scotland ministers, were ordained between the ages of 25 and 34 years. Only 6 per cent (13: 217) were late entrants to the ministry, being ordained in excess of 40 years of age.

However, like their colleagues who had suffered early death, these men had been highly mobile even though none of them had completed a full term in the active ministry (See Table 37, over). It is quite notable that 132 of these men (i.e. 60.8%) had occupied three or more parishes. Those who retired between 65-69 years were in what would normally have been the last five years of their active ministry and 81 of these (i.e. 61.5%) had occupied three or more

(1) Refer to Chapter 9, q.v.

TABLE 37 : NUMBER OF PARISH CHARGES AND AGE

Age	No. of Charges							Unknown
	1	2	3	4	5	6	7	
65-69	8	36	37	21	15	4	4	6
Under 65 years	13	20	23	15	11	2	-	2
TOTAL	21	56	60	36	26	6	4	8

parishes. Only 21 of the total (i.e. 9.6%) had held one charge throughout their ministries and 8 of these were aged 65 years or more. These facts simply demonstrate their mobility as a group.

This aspect of their experience is in marked contrast to that of their colleagues who had achieved notable longevity.⁽¹⁾ It is an outstanding fact that 36 or 16.5 per cent of these men had held more than five parishes over periods of less than forty years, and in 4 instances men had held as many as seven parishes. Such occupational and geographical mobility seems to have been an important feature of their experience. The importance of this fact in relation to their health is indeterminable but should not be overlooked.

The nature of the last parishes occupied by these men is not necessarily significant, especially in view of their mobility. But it may be an important factor in those cases in which men had held their last parish for at least ten years prior to disablement. A simple comparison of the types of parishes held by these men may be made on the basis of the local population of the areas in which these parishes are set (See Table 38, over). Too much importance should not be

(1) Chapter 9, q.v.

attached to these figures, but some interesting and possibly significant features do emerge.

TABLE 38.: TYPE OF PARISH AND YEARS

Local Population	Total	1/4	5/9	10/19	20/29	30+
100,000+	58	5	10	14	23	6
50,000+	14	-	3	2	7	2
20,000+	16	-	3	4	3	6
10,000+	5	-	1	3	1	-
5,000+	13	1	3	2	3	4
-5,000	102	15	27	28	16	16
Unknown	9	-	-	-	-	-
TOTALS	217	21	47	53	53	34

First, it can be observed that, even though these men had been extremely mobile over their whole careers, most of them spent more than ten years in their last parish prior to ordination: this applies to 140 or 64.6%, in which case the nature of their last parish may be of some importance for the individual's health.

In the second place, a large proportion of these men occupied parishes in the more densely populated, urban, industrial areas of Scotland. A total of 58 held parishes in the four major cities, with populations in excess of 100,000, and 43 had done so for more than ten years, 29 for more than twenty years. In addition, a further 14 held parishes in smaller cities and large burghs with populations of more than 50,000. This means that, in all, 72 (i.e. 33.1%) occupied parishes in the major urban areas of Scotland and 54 had done so for at least

ten years (38 for more than twenty years) prior to their disablement.

An even more striking feature of this information, thirdly, is the very high proportion who held parishes in more remote, sparsely populated, rural areas, especially in the highland, islands, and border areas. The number in small towns, villages, and rural areas, with populations below 5,000, was 102, almost one half of the total. Some of these, 18 in all, although classified as rural, were situated in the central belt of Scotland in relatively close proximity to the main centres of population. When allowance is made for these, 84 (i.e. 38.7%) of the ministers who had been disabled were in rural parishes scattered throughout the highlands, islands, and borders at the time of their retirement. This leaves a total of only 34 ministers from parishes in the numerous small towns and burghs with populations between 5,000 and 50,000.

It seems reasonable to conclude that the risk of disablement for Church of Scotland ministers is equally great for those ministers who spend an extended period of time in either the urban, industrial areas, especially in the so-called central belt of Scotland, or in more remote, rural areas. It is particularly unusual, and perhaps unexpected, to note that the risk of disablement appears to be greatest for those ministers who spend more than ten years in remote, sparsely populated, rural parishes.

3. CAUSES OF BREAKDOWN

In each case of disablement to come before the Committee the cause of breakdown is carefully diagnosed, as far as this is medically possible. The diagnosis is supported by appropriate medical evidence. If the Committee's medical advisor considers that the evidence does not adequately establish permanent disability he may then seek additional

TABLE 39 : CAUSES OF DISABLEMENT, CHURCH OF SCOTLAND, 1950-1968.

INTL. CLASS.	CAUSE.	1950	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	70
	TOTAL - ALL CAUSES	11	16	11	12	16	14	13	13	12	9	8	11	10	7	12	15	8	12	7	217
001-19	T.B.	1	1																		2
140-205	MALIGNANT NEOPLASMS		2		2			2				1		2	1						10
240-245	Allergic Diseases e.g. Asthma			1							1		2			1		1			6
260	DIABETES MELLITUS		1		2	2	1	1	1						1		1		1		11
270-289	Diseases of other Endocrine glands							1	1								1				2
290-299	Anaemias			1					2												3
300-309	PSYCHOSIS													1	1	2			1	1	6
310-326	PSYCHONEUROTIC DISORDERS		2	1	1	1	1			2		1		1		2	1		4	1	18
320-326	PERSONALITY DISORDERS	1											1						1		3
330-334	Vascular lesions affecting the C.N.S.	2	2	3	2			1	1	2	2		3	3	1			4	4	2	34
340-357	Other diseases of the C.N.S.			1		2	1	2	2	1	1	1				2		1		1	15
370-389	Diseases and conditions of the eye				2				1	1					2	1	1	2			10
410-443	HEART DISEASES (Total)	7	5	1	4	9	4	5	5	6	6	4	4	1	3	5	7	3	3	1	83
420	Coronary Thrombosis	3	1	1	2	3	1	2	2	4	5	1	2	1	1	5	5	1	2	1	43
421-432	Myocardial degeneration	4	3		1	6	3	4	1	2		2	1		1	1	1	2	2		35
430-434	Other Heart Disease		1		2	1	1		1	1	1	1	1		1		1				12
440-443	Hypertensive Heart Disease		2			3	1	1	1	1	2		1		1		1				14
450-456	Arteriosclerosis	1	2	1				1	1	3	1	1		2	1		1	1	1		17
444-457	Other Hypertensive Disease		2	2		2		1	1	1	1						1	2	2	2	17
460-468	Other Diseases of the Circulatory System	1			1								1				1				4
500-502	BRONCHITIS	1	1					2				2	1	2		1			1	1	12
510-527	Other Diseases of the Respiratory System		1			1				1			1	1	1				2		8
540-545	Diseases of the Stomach/Duodenum		1	2				2	1	2			1			2			1		12
560-568	Other Diseases of the Digestive System	1	1	2	1	2	1	1	1					1	1		1		1		14
590-617	Diseases of the Genito-Urinary S.	1	2						2	1											6
720-727	ARTHRITIS and RHEUMATISM	1						3			1			2	1	1		1			10
730-749	Other Diseases of the Musculoskeletal S.			1	1	1	1			1	1						1				7
760-764	Diseases referable to Organs & Systems					2	1								1	1	1		1		7
780-795	Sensitivity and ill-defined symptoms	1	1			1	1			2	1		1	1			1				10
-	Unknown		1		1		2			1			1	1			1				8
	TOTAL DIAGNOSES	18	27	17	17	26	24	21	24	22	14	11	22	12	13	17	24	15	21	9	350

evidence from the general practitioner concerned or may seek specialist opinion. In any event, the Committee, through its medical advisor, has to be satisfied that the individual minister's infirmities have rendered him incapable of continuing to work in the active ministry.

These 217 cases of disablement yielded a total of 350 diagnoses, which results from multiple causes diagnosed in a number of individual cases. All causes of disablement are presented in detail in Table 39 q.v. and have been classified according to the International Classification, 1955 Revision.⁽¹⁾

TABLE 40 : PRINCIPAL CAUSES OF DISABLEMENT,
1950 - 1968

Cause	Total Cases	% Diagnoses	% Cases
1. Heart Diseases	83	23.7	38.6
(Coronary disease)	(43)	(12.2)	(20.0)
2. Vascular lesions affecting the C.N.S.	34	9.4	15.3
3. Mental, Psychoneurotic, or Personality Disorders	26	7.1	11.8
4. (a) Hypertensive disease without heart disease	17	4.8	7.9
(b) Arteriosclerosis	17	4.8	7.9

The causes of disablement of Church of Scotland ministers have been varied, but five principal causes stand out: heart diseases, vascular lesions affecting the C.N.S., psychiatric disorders, hypertensive disease, and general arteriosclerosis. As was evident in mortality data, all forms of heart disease have been the greatest cause

(1) World Health Organisation (1957), op.cit.

of disablement and coronary heart disease, in particular, has contributed to more cases of incapacity than all other forms of heart disease together.

These five principal causes of breakdown have been followed by bronchitis (12), diseases of the stomach and duodenum (12), other diseases (e.g. Parkinson's and disseminated sclerosis) of the Central Nervous System (12), diabetes mellitus (11), malignant neoplasms (10), arthritis and rheumatism (10), and diseases and injuries of the eye (10). It should also be noted that there have been 14 cases in which hypertension was associated with heart diseases, which means that hypertensive disease was involved in a total of 31 cases.

(i) Infective and Parasitic Diseases. This class of diseases has made an insignificant contribution to the disablement of Church of Scotland ministers in this period. Only two confirmed cases of pulmonary tuberculosis have been reported, both of which occurred before 1953. Two possible cases of tuberculosis of the genito-urinary system were reported, but had not been confirmed.

(ii) Malignant Neoplasms. It was observed earlier that Church of Scotland ministers experience an unusually low incidence of cancer. This is further demonstrated by these cases of disablement. Cancer was diagnosed in only ten of these cases (i.e. 4.6%) and it is of particular note that none were attributed to cancer of the lung or respiratory system. One serious case was diagnosed as being secondary carcinoma affecting a number of vital organs, while the remainder were sited in the prostate, rectum, lymph glands, salivary glands, spine, and stomach.

(iii) Mental, Psychoneurotic, and Personality Disorders. Mental health is one dimension of health and illness which is not illuminated by mortality data and to this point no explicit reference has been made

to the mental health of Church of Scotland ministers. All those disorders generally classified in the group of Mental, Psychoneurotic, and Personality Disorders have been the third greatest cause of disablement, being involved in 26 or 11.8% of all cases between 1950-1968. This group, however, includes a wide variety of conditions and complaints.

Among these, six cases had been diagnosed as psychoses, including three classified as manic-depressive psychosis, two as schizophrenia associated with bizarre behavioural problems, and one as endogenous depression which was likely to be a permanent condition following a cyclic pattern. It is worthy of note that each of these cases had arisen in the period since 1960.

The psychoneuroses, expectedly, affected a larger number of these men (18) and in each case the complaint was considered to be of sufficient intensity to constitute a more or less permanent incapacity for work. The most prevalent forms of psychoneurosis suffered by these men were severe reactive depression (7) and acute anxiety states (6). It may be that some cases of depression, which had evidently been long-standing and severe, would be more appropriately described as being endogenous rather than reactive in nature, but this was not made clear in the recorded diagnoses. In any event, the depression was of sufficient intensity to prove incapacitating. The remaining cases in this group were less precisely described as "psychoneurosis", "neurasthenia", "severe nervous exhaustion", or "nervous tension". In each case it was considered unlikely that the minister concerned could continue to work effectively. It should be recorded that in these cases involving psychoneurotic conditions disablement was not usually attributed to a single cause.

Very few cases of personality and behavioural disorders have been reported. These included one case of alcoholism and two of deviant sexual behaviour. If anything, by comparison with other clergy groups,⁽¹⁾ there have been an unusually low number of cases in this category.

Some pertinent observations may be offered. First, as far as can be judged from these cases of disablement, it would seem that psychiatric illnesses and disorders are not particularly prevalent among Church of Scotland ministers. Even though these difficulties have been the third greatest cause of disablement and have been diagnosed in 11.8% of all these cases, this is not excessive. When considered in relation to the total population at risk in this period, these 26 cases affect less than 0.5% of the total population of Church of Scotland ministers (or a rate of approximately 8:1,000). What evidence does exist suggests that Protestant clergymen are no more prone to mental illness than the general population; indeed, there is some evidence to suggest that in some respects they enjoy a favourable standard of mental health. In the case of Church of Scotland ministers it is true to say that comparatively few of them have been permanently incapacitated by mental, emotional, and personality disorders. By comparison with the clergy group in the U.S.A. studied by Meiburg and Young the experience of Church of Scotland ministers is relatively favourable. In that particular study it was reported that 18% had been hospitalized due to "mental, psychoneurotic, and personality disorders" and these disorders comprised the greatest single cause of hospitalization.⁽²⁾

It is questionable, however, to draw too sweeping conclusions with reference to the mental health of Church of Scotland ministers from these few cases of disablement. They may provide an unduly favourable

(1) See Chapter 2, q.v.

(2) A.L. Meiburg and R.K. Young (1958), op.cit. Also refer to Appendix I: Table IA.

and misleading impression. Mention has already been made of the many unknown quantities in this realm. Nothing is known, for example, of the number of ministers who manage to conceal serious personal difficulties or who seek private psychiatric care, nor of the frequency with which ministers are hospitalized as a result of such disorders, nor of those cases in which ministers have resigned in order to avoid disciplinary action or disrepute. There is no doubt that some of those who suffer severe psychiatric disorders and who urgently require specialized care are forced, directly or indirectly, to withdraw from the ministry. The result is that the true position is concealed or distorted and cannot be established without more intensive investigation.

In absolute numbers, cases of disablement have steadily decreased as has the total population of Church of Scotland ministers. The decrease has been correlative. However, it can be seen, secondly, that the proportion of cases attributed to mental, emotional, and personality disorders has increased since 1960: 16 of these 26 cases have arisen since then. Those cases diagnosed as psychoneuroses have been evenly distributed over the entire period, but all the cases involving psychoses and behavioural disorders have occurred since 1960. Moreover, these disorders have affected men in younger age groups. Between 1950-1959 only one minister under 60 years of age was disabled by psychiatric illness. Since 1960, however, ten men under 60 years of age have retired due to disabling psychiatric illnesses and disorders.

This development may indicate an increase in the prevalence of mental, emotional, and personal disorders in the ministry of the Church of Scotland, especially in younger age groups, or it may simply reflect changes in attitudes and procedures which have made it more acceptable for men to retire on such grounds without fear of disrepute. The

manner in which some of these cases has been officially handled suggests a more sympathetic approach to such circumstances. In at least four cases the department Secretary in collaboration with the appropriate Presbytery Clerk had taken the initiative to ensure that the men concerned received suitable treatment and gained adequate retiral benefits. This was done, for example, in both cases involving deviant sexual behaviour. The action was undertaken in these instances in a discreet and compassionate manner with the full intent of exercising effective pastoral care.

The unofficial pastoral activities carried out by senior administrators in these few cases is a positive step. Nevertheless, one could reasonably expect a higher incidence of acute psychiatric disorders among Church of Scotland ministers. It is certain that more ministers have suffered from such difficulties. But what becomes of such men and whether or not they ever receive adequate care and treatment is concealed. There is little provision for the pastoral care of ministers within the structure of the Church of Scotland. Theoretically, each minister is under the oversight of a Presbytery, a corporate body of clergy and laity. But it is questionable whether such a large and basically administrative body is ever capable of exercising pastoral care toward individuals. No particular individuals are entrusted with the responsibility of exercising such care, except in the case of one Presbytery which has taken the unusual step of appointing confidential counsellors and advisors.⁽¹⁾ In general, it is left to the minister who experiences personal difficulties to exercise initiative in seeking his own counsel and treatment. This may in fact be an

(1) This refers to the interesting experiment established by the Presbytery of Edinburgh (Chapter 2, q.v.).

effective 'system' in all but the most extreme cases, when a man's lack of insight, social isolation, guilt, or fear of disciplinary action render him incapable of taking the initial step in seeking help. The fear of disciplinary action should not be under-rated, especially as such difficulties and conditions have been not uncommonly regarded as matters requiring disciplinary action rather than pastoral care, and have been dealt with on a legalistic basis rather than in terms of grace when they have been brought before the Courts of the Kirk. The disciplinary procedures of the Kirk have been rarely invoked in cases involving errant ministers since the last World War. But there is sound reason to believe that, instead, a number of unofficial procedures for dealing with such embarrassing circumstances have become operative. In some instances the outcome may be positive and beneficent. However, although it may be a cynical observation, one has reason to suspect that the well-being and care of the individual minister is not always the primary consideration behind such manoeuvres. It was established as early as 1943 that the clear consensus of opinion throughout the Church of Scotland is that the provisions for the pastoral care of ministers are inadequate and ineffective.⁽¹⁾ The position has not altered to any appreciable extent in the interval, and this is of particular concern in circumstances involving acute psychiatric disorders.

(iv) Diseases of the Nervous System and Sense Organs. Vascular lesions affecting the Central Nervous System (including cerebral thrombosis, cerebral embolism, and cerebral arteriosclerosis) have been the second greatest cause of disablement among Church of Scotland

(1) Reports to the General Assembly, 1943 (report of the Commission for the Interpretation of God's Will in the Present Crisis). See Chapter 2, q.v.

ministers, which is consistent with mortality data. These disorders are usually associated with the ageing process and their prevalence increases substantially with age. In these cases, disablement due to vascular lesions affecting the Central Nervous System were confined exclusively to those aged 60 years or more. In a number of these instances hypertensive and arteriosclerotic conditions were also present.

The cases of disablement attributed to other diseases of the Central Nervous System included disseminated sclerosis (3), Parkinson's disease (5), various forms of paralysis resulting from cerebral accidents (4), petit mal epilepsy (1), acute migraine (1), and total amnesia (1). Other physical symptoms and conditions were also present in most of these cases.

The ten cases in which ministers were incapacitated by injuries and diseases of the eye all occurred in the over 60 age group. At least three of these were the result of war-time injuries.

(v) Diseases of the Circulatory System. All the evidence reveals that Church of Scotland ministers tend to be particularly vulnerable to diseases of the Circulatory System, and this is quite apparent in both their mortality and morbidity experience. Diseases of the circulatory system were diagnosed in 121 or 56.8% of these cases. By comparison, diseases of the nervous system and sense organs were present in 59 or 27.6% of the total.

As could be anticipated from mortality data, more ministers have been disabled by heart diseases than by any other single cause: 83 of these men (i.e. 38.6%) had been afflicted by various forms of heart disease, and in a number of individual cases more than one variety of heart disease had been diagnosed.

It comes as no surprise, in the light of mortality data, to discover that coronary heart disease has been the greatest cause of

disablement among Church of Scotland ministers throughout this period. Coronary heart disease was diagnosed in 43 (i.e. 20%) of these cases, so that this disease assumes importance as a crippling as well as fatal agent in the experience of this clergy group. There is no evidence of an increase in the frequency of coronary disease as a cause of disablement over this period, 1950-1968. Between 1950-59 this disease was present in 18.8% of all cases of disablement, while between 1960-68 it has been identified in 21.1% of these cases, which represents a marginal increase of little more than 2% in the latter period. However, there may have been a significant change in the age at which coronary disease occurs. *

TABLE 41: INCIDENCE OF CORONARY HEART DISEASE

Period	Total	% Total Cases	% Under 65 years
1950-59	24	18.8	29.1
1960-68	19	21.1	36.8
TOTAL	43	20.0	32.5

It has been seen that coronary disease has been the greatest cause of death among Church of Scotland ministers and that it has been most excessive in the age group over 65 years of age. Attention has also been drawn to the fact that coronary disease has been afflicting younger men in recent years. This is further demonstrated by the experience of those who have been disabled. The overall rate of disablement from coronary disease has not increased significantly from 1950 to 1968, but younger aged men have become more prone to this disease. The incidence of coronary disease increases rapidly with age and most

cases have been recorded in the 65-69 age group. But, according to this morbidity data, the proportion of ministers under 65 years of age suffering from this disease increased by more than 7%, from 29.1% in 1950-59 up to 36.8% in 1960-68.

In the diagnoses of each of these 43 cases, coronary heart disease is referred to as the primary cause of disablement and in 19 cases coronary disease is the sole cause. However, in more than half of these cases complementary or secondary causes are observed. Most commonly coronary disease appears together with vascular lesions affecting the Central Nervous System, other varieties of heart disease, hypertension and arteriosclerosis.

Apart from heart diseases in general, and coronary disease in particular, other diseases of the circulatory system have also made a significant contribution to the disablement of ministers. This applies particularly to hypertensive disease and general arteriosclerosis. Like vascular lesions affecting the Central Nervous System, arteriosclerosis (17 cases) rapidly increases in incidence with age and is confined mainly to the 65-69 age group. The cases in which hypertensive disease has been present are of particular interest. Hypertension has been diagnosed in 31 cases (i.e. 14.2%), which makes it the third greatest cause of disablement, and in 14 of these hypertension was associated with heart disease. Most of the remaining cases were explicitly described as being malignant or essential hypertension. Closer examination reveals two interesting features. First, the incidence of hypertensive heart disease has declined while essential hypertension has remained relatively constant throughout this period. Second, although hypertensive disease increases with age, almost one half of all these cases have occurred in ages under 65 years which contrasts with vascular lesions affecting the Central Nervous System

and arteriosclerosis, both of which mainly affected the 65-69 age group.

(vi) Other causes of disablement. There have been many other causes of disablement, but the only ones which stand out have been diabetes mellitus (11), bronchitis (12), disorders of the stomach or duodenum (12), arthritis and rheumatism (10), each of which has been involved in approximately 5 per cent of the total.

Cases involving Allergic, Endocrine System, Metabolic, and Nutritional Diseases have been 19 in all (i.e. 8.9%). These have comprised diabetes mellitus (11), chronic asthma (6), and thyroid disorders (2). As noted in mortality data, diabetes appears to be more common than would normally be expected.

Once again, all Diseases of the Respiratory System appear to have an unusually low incidence in this clergy group. Bronchitis and emphysema, together with arthritis, are among the major crippling illnesses and disorders in Western Societies and it is known that they have an unusually high incidence in Scotland, particularly in and around the Glasgow conurbation. Against this background, the experience of Church of Scotland ministers appears to be most positive. Respiratory diseases have contributed to 20 (i.e. 9.3%) of these cases, and have included 12 cases of bronchitis and 2 of emphysema.

Diseases of the Digestive System, involved in 26 cases (i.e. 12.2%), included 9 ulcerative conditions, chiefly affecting the duodenum. In a further two cases earlier gastrectomies had been performed, but the original cause was not specified in either case. Other complaints in this category included dyspepsia (2), chronic constipation (1), hernia conditions (3), and diseases of the colon or rectum (5). Diseases affecting the liver included cirrhosis of the liver (3) and jaundice (2).

Diseases of the Genito-Urinary System were involved in relatively few of these cases. They were diagnosed in 6 cases (i.e. 2.8%). By contrast, 12.5% of the sample of hospitalized clergy studied by Meiburg and Young (1958)⁽¹⁾ suffered from such complaints.

Diseases of the Bones and Organs of Movement, a total of 17 (i.e. 7.9), have mainly involved arthritic and rheumatic conditions (10). These have included osteoarthritis of the spine (3), arthritis of the spine (1), arthritis of the knees (2), unspecified arthritis (2), rheumatoid arthritis (1), and general rheumatism (1), and have chiefly affected men in the 65-69 age group. With one exception, all other disorders of the Musculoskeletal System involved forms of bone damage and injuries, four of which were the direct result of war injuries.

The remaining cases included 3 involving the blood and Blood-Forming Organs (including one of pernicious anaemia), 7 involving symptoms referable to organs or systems (such as angina or renal colic), and 10 less explicitly diagnosed as being indicative of senility or senile deterioration.

It can be seen that the disablement of Church of Scotland ministers in the period 1950-1968 has been the outcome of a wide variety of conditions and diseases. Most of these cases have resulted from a constellation of symptoms and disorders, and, except in those cases involving coronary heart disease and those attributed to psychiatric disorders, disablement has been rarely ascribed to a single cause. It is evident, in general terms, that the morbidity and mortality experiences of Church of Scotland ministers are consistent. The main causes of disablement have been heart diseases, especially coronary disease, vascular lesions affecting the Central Nervous System,

(1) A.L. Meiburg and R.K. Young (1958), op.cit.

hypertensive disease, general arteriosclerosis, and psychiatric disorders. This is consistent with mortality data and the low incidence of both respiratory diseases and malignant neoplasms among Church of Scotland ministers is further demonstrated. The only new feature of their experience to emerge from this morbidity data is the prevalence of incapacitating mental, emotional, and personality disorders, which, in any case, do not appear to be unusually excessive.

4. MORTALITY OF THE DISABLED

A brief examination of the mortality experience of those ministers who have been disabled illustrates the fact that a substantial proportion of given population may be crippled and incapacitated without affecting the mortality experience of the entire population. Even though these ministers had been permanently incapacitated and had been lost to the active ministry before reaching retiral age, a substantial number of them have managed to survive for many years despite their disabilities.

TABLE 42: SURVIVAL AND MORTALITY OF THE DISABLED
(at Dec. 31st, 1969)

	Total	-45	45/49	50/54	55/59	60/64	65/69	70/74	75+	Un- known
Deceased	127	-	3	3	6	18	40	31	26	-
Survivors	90	2	3	2	5	9	23	19	27	1

By December 31st 1969, 127 of these men had died, leaving 90 survivors. Most deaths have occurred in the 65-74 age group, in many cases within a few years of retirement. In fact the majority of these men, 90 in all, have died within five years of their retirement. Nevertheless, it is interesting to note that an appreciable number of these men have survived 75 years in spite of the afflictions which led

to their early retirement. Of those who have died, 26 have been in excess of 75 years, while 27 of the survivors are now aged 75 years or more. Moreover, 20 of those who have died survived for ten years or more beyond their retirement.

Considering that these men had been incapacitated by serious illnesses and complaints, their capacity for survival has been remarkable. The average age of death of those who have died has been 66.8 years, which is several years below the average age of death of Church of Scotland ministers through this period but is, nonetheless, close to the average length of life of Scottish males.⁽¹⁾ Despite their capacity for survival, however, the health experience of these ministers has obviously been much less favourable than that of most of their colleagues in the Church of Scotland ministry.

GENERAL CONSIDERATIONS

When all attention is focussed on morbid, pathological conditions, such as those involved in these cases of disablement, there is always the danger of distortion. It cannot be said that these particular ministers are representative of the typical health experience of Church of Scotland ministers. At the most, the experience of these ministers reveals the peculiar health hazards to which ministers are most prone and from which they are most likely to be disabled. To be seen in perspective, however, it must be borne in mind that they represent 6 per cent of the total population over this period. Moreover, most of these men were in the last few years of their active ministry at the time of disablement; although there is also clear evidence that a growing number of younger men have been disabled in recent years. In particular, it would seem that coronary disease and psychiatric complaints have been

(1) Chapter 8, q.v. and see Appendix II: Table 2B.

affecting a younger group of men in the last decade. Nevertheless, a relatively small proportion of Church of Scotland ministers have been permanently incapacitated over this period and their experience should not be regarded as typical. But, when considered together with mortality data, this morbidity data does reveal some general features of the experience of Church of Scotland ministers.

(i) Positive health record

First, Church of Scotland ministers generally enjoy a very favourable health experience at least up to about the age of 45 years. Mortality data showed that the death rate of Church of Scotland ministers under 45 years of age is remarkably low by comparison with Scottish males and other occupational groups. Morbidity data provides further evidence of this fact. Between 1950-68 only six ministers under 45 years were permanently incapacitated, and all of these have occurred since 1960. One of these men suffered from a serious physical disorder (disseminated sclerosis). The others were all incapacitated by severe mental and emotional complaints associated with acute anxiety states and depression. In each case it was considered that the individual minister concerned required specialized, long-term psychiatric treatment and was unlikely to return to the active ministry. This aspect of the experience of Church of Scotland ministers was not revealed by mortality data, and since these particular ministers only represent the extreme cases one would expect that depression and anxiety states are more widely prevalent in the ministry than these figures reveal. How prevalent such conditions are in fact cannot be determined without more intensive investigation. This observation, however, should not be allowed to detract from the indisputable fact that Church of Scotland ministers enjoy a very high standard of physical health, especially up to 45 years of age.

(ii) Personal habits and physical conditions

In the second place, all the evidence tends to suggest that the physical conditions of ministers' lives, including personal habits, standards of hygiene, living and working conditions, are basically beneficial and generally foster a relatively high standard of health. Diseases and disorders which are commonly associated with unhealthy personal habits, unsatisfactory standards of living, or detrimental working conditions are relatively uncommon among Church of Scotland ministers. In varying degrees, for example, tuberculosis and other infective and parasitic diseases, accidents of any kind, all diseases of the respiratory system (including bronchitis, emphysema, and pneumonia), various digestive diseases and complaints, cirrhosis of the liver, and cancer of the lung make little or no contribution to the death or disablement of these ministers. On the basis of the evidence, it would seem justified to conclude that ministers generally look after themselves and protect their physical health and that the physical conditions of their environment support a high standard of physical health. Illnesses and complaints which may be attributed, to some extent at least, to excessive smoking or drinking, inadequate exercise, unsuitable or inadequate diet, unsatisfactory hygiene standards, personal self-neglect or abuse, or detrimental working conditions, are not much in evidence.

There is a danger, of course, of oversimplification in this regard. The aetiology of some of these illnesses and diseases involves complex cause-effect relationships and it is perhaps facile to simply ascribe them to more obvious physical factors. Moreover, the possibility exists that personal habits or the physical conditions of an occupation make some contribution to some of those diseases, like coronary disease,

which have had a prominent place in the mortality and morbidity experiences of these ministers. But the evidence to support this general conclusion is convincing, if not absolutely conclusive.

(iii) Coronary heart disease.

The significance of coronary heart disease, thirdly, deserves special mention. There is no doubt that Church of Scotland ministers are particularly vulnerable to coronary heart disease, and more ministers are incapacitated by and die from coronary disease than from any other single cause. It has been argued that this is not a recent development: it is probable that coronary disease has been excessive among these ministers throughout the period from 1930 up to 1969. Evidence has been presented which suggests that there has been a slight increase in the incidence of coronary disease among these ministers, especially since 1960 and particularly among younger men under the age of 65 years. However, considering the fact that coronary disease has been excessive throughout the period under study and in view of the fact that it is much more prevalent in other professional groups, the magnitude of this increase should not be exaggerated, but nor should the importance of this disease in the experience of Church of Scotland ministers be under-rated or overlooked. Why ministers should be particularly susceptible to coronary heart disease is not self-evident, nor is it easily discovered.

Coronary heart disease, as a cause of morbidity and mortality, has steadily increased in prevalence, especially in the male population and particularly in urban-industrial societies. According to one estimate, the incidence of coronary disease among British males is now six times greater than in 1937.⁽¹⁾ Coronary disease has been described

(1) A.L. Wingfield, "How not to get a coronary" (B.M.A. Booklet, 1969).

as one of the "afflictions of civilization";⁽¹⁾ and the fact that it is almost unknown among some primitive communities and races⁽²⁾ suggests that there is some relationship between coronary disease and the conditions of modern urban-industrial societies. Professor F.A.E. Crew has included coronary disease, together with malignant disease and cerebral haemorrhage, embolism, and thrombosis, in the list of "diseases of plenty" which evidently "follow upon urbanization, industrialization, and rising standards of living" and which appear to be associated with smoking, eating and drinking too much, too little exercise, too much worry over trivia and inconsequential matters, and misspent leisure.⁽³⁾ There certainly appears to be a general relationship between coronary disease and the conditions of life in advanced technological communities, but it has proven difficult to identify the specific causal factors involved in this relationship.

The issue is complicated by the fact that the distribution and prevalence of coronary disease varies appreciably according to socio-economic status and occupation, even in those societies in which it is generally widespread. It has been established that coronary disease is most common in Social Classes I and II and among professional, administrative and executive occupations.⁽⁴⁾ Some exceptions to this general pattern have been identified, but they are quite unusual and atypical.⁽⁵⁾ In addition to research devoted to investigating the physiological and

(1) R. Dubos and M. Pines, *op.cit.*, p. 84 ff.

(2) *Ibid.* It is almost unknown, for example, among Australian aborigines.

(3) F.A.E. Crew, *op.cit.*, p. 49.

(4) For valuable discussions of these variations see S.L. Morrison (1957), *op.cit.*, and Ryle and Russell, "Critical review of the Registrar General's Report on Occupational Mortality, 1931", British Heart Journal, 1949.

(5) It has been observed, for example, that New York taxi-drivers experience an abnormally high rate of coronary disease. An unusually high rate of coronary disease has recently been reported on Tiree, one of Scotland's Western Isles with a small, scattered population, mainly comprising crofter families.

biochemical factors involved, the apparent correlation between coronary disease and both socioeconomic status and occupation has led to intensive investigations into a wide variety of factors: psychological, social, occupational, and environmental. The results, as yet, are far from conclusive and the causation of coronary disease continues to be an enigma and a subject of dispute.

Many hypotheses are currently under consideration. A number of innate factors, including heredity, blood factors, sex, age and race, have been investigated and there appears to be a general relationship between such factors and coronary disease. These factors, however, do not adequately account for the marked occupational and socio-economic variations in the incidence of this disease.

There is considerable evidence to indicate that coronary disease may be closely associated with harmful personal habits. There seems to be little doubt that excessive smoking, inadequate exercise, and a diet rich in fats may contribute to coronary conditions. For example, a series of studies by Russek and his associates (1959, 1960, 1965)⁽¹⁾ indicated a close relationship between coronary disease and both tobacco and diet, and there is a wealth of supporting evidence from other sources. It has been argued that this may partially explain the marked occupational variations and that coronary disease is most prevalent within those Social Classes and occupational groups which enjoy a high standard of living and whose socio-economic status and income makes luxuries

- (1) H.I. Russek, "Stress, tobacco, and coronary disease in North American professional groups", Journal of the American Medical Association, 192, April 1965; H.I. Russek and B.L. Zohman, "Relative significance of heredity; diet, and occupational stress in coronary heart disease in young adults" American Journal of Medical Sciences, 235, March 1959.

readily available.⁽¹⁾ Another author, J.N. Morris (1960), has contended that there is not a significant relationship between Social Class as such and coronary disease. Closer examination, he maintains, reveals that the incidence of coronary disease increases in relation to the degree of physical inactivity involved in specific occupations.⁽²⁾ In other words, coronary disease is most typical of "sedentary occupations", irrespective of their social classification and status. However, although smoking, diet, and exercise may undoubtedly affect the incidence of coronary disease, no absolute or exclusive causal link has been established.

In recent years much attention has been given to the possible relationship between emotional stress, especially occupational stresses, and coronary disease. Ryle and Russell (1949), from an examination of the data provided by the Registrar General for England and Wales for 1931, found that coronary disease was most prevalent among physicians and surgeons, followed by proprietors of wholesale businesses, judges and solicitors, and then Anglican clergymen. They concluded: "...existing conditions of work in many professional and business careers impose strains which, when endured too long, are beyond physical tolerance.....mental activity, unlike manual labour, cannot be readily limited by legislation or arrested by the clock".⁽³⁾ The

- (1) For example, S.L. Morrison (1957), op.cit., who attributed the relatively lower incidence of coronary disease among Scottish clergy and teachers in 1947-53 to declining standards of living. But, as mentioned earlier (Chapter 9, q.v.), the validity of his argument is dubious.
- (2) J.N. Morris, "Epidemiology and cardiovascular disease of middle age: Part I," Modern Concepts of Cardiovascular Disease, 1960, 29.
- (3) Ryle and Russell (1949), op.cit.

clear assumption is that those occupational groups within which coronary disease is excessive are subject to peculiar "strains" and that constant mental activity, in particular, imposes special stresses. However, "stress" is an indefinite expression and could refer to a variety of circumstances and experiences and "mental activity" is difficult to measure or evaluate. Nevertheless, there is much evidence to indicate that emotional stress plays a significant part in the aetiology of coronary disease.

Russek and his associates, for example, have conducted a series of studies to investigate the roles of heredity, diet, and emotional stress in the causation of coronary disease.⁽¹⁾ In one study, Russek and Zohman (1959) found that at least two of these factors were present in 95 per cent of a sample of coronary patients compared with only 12 per cent of a control group of hospital patients,⁽²⁾ which suggested that coronary disease was probably the outcome of a combination of factors, including emotional stress.

Pearson and Joseph (1963) have subsequently attempted to establish the frequency, severity, and nature of the emotional stresses experienced by coronary patients.⁽³⁾ Their study was particularly concerned with stresses involved in work, travel to and from work, home and family life, and leisure activities. The most productive sources of stress experienced by coronary patients were the home and work, and occupational stresses were chiefly associated with interpersonal difficulties rather than with the nature of the work itself.

(1) For a selection of publications by Russek et al refer to the Bibliography.

(2) H.I. Russek and B.L. Zohman (1959), op.cit.

(3) H.E.S. Pearson and J. Joseph, "Stress and occlusive coronary-artery disease", The Lancet, Feb. 23, 1963, 1.

An unusual series of studies, led by Syme (1964, 1965), have considered the possible relevance of occupational and geographical mobility.⁽¹⁾ They revealed that coronary disease was more prevalent among those who had had four or more occupational changes and among those who had two or more cross-country moves. It was inferred from these studies that the social discontinuity and status inconsistency arising from such mobility are productive of chronic stress which is eventually manifested in coronary disease. The association is purely circumstantial, but it is interesting to consider the experience of Church of Scotland ministers in the light of these findings. It has been seen that these ministers are extremely mobile, usually experiencing a number of occupational and geographical changes during their careers. It has also been shown that those who achieve notable longevity are relatively less mobile, while those who have suffered early disablement have been relatively more mobile than is usual. A comparison of the experience of those ministers disabled by coronary disease between 1950-68 (a total of 43 cases) with that of those disabled by all other causes (174 cases) reveals that the former had been generally more mobile than the latter: 72 per cent of the coronary patients had held three or more parishes prior to retirement compared with 58 per cent of the remainder.⁽²⁾ Both groups had led unusually migratory lives, as is typical of Church of Scotland ministers, but this was even more marked in the case of those who suffered from

(1) S.L. Syme, M.M. Hyman, and P.E. Enterline, "Some social and cultural factors associated with the occurrence of coronary heart disease", Journal of Chronic Diseases, 1964, 17; and Syme et al, "Cultural mobility and the occurrence of coronary heart disease", Journal of Health and Human Behaviour, 1965, 6.

(2) See Table 38, q.v.

coronary conditions. This may be purely circumstantial, but it is an unusual contrast.

Another important group of studies, in the field of Psychosomatic Medicine, suggests that the stresses and conflicts associated with coronary disease arise out of the individual's personality. A "coronary personality" has been postulated. This predisposing personality type is characterized by egocentricity, self-absorption, and ambitious striving, while concealing basic feelings of inferiority and insecurity. This personality is inclined to compulsive striving, evident in perfectionism and meticulous competence in work, while at the same time seeking reassurance, attention, and affection, expressed in excessive sociability and a desire to please. The coronary personality's driving ambition and wish to be liked, which may not be complementary, may produce a tendency to self-neglect and stoic self-denial, through lack of sleep, long hours of work, little relaxation, and physical neglect. The main conflicts for the coronary personality tend to focus on authority and sexual problems. On one hand, his ambition and wish to succeed leads to conflict with and possibly aggressive rebellion against authorities and to a tendency to be dominant and aggressive in interpersonal relationships, and even social relationships and conversations may be used as means of domination. On the other hand, the same ambition together with a deep need for affection tends to interfere with sexual relationships and sexual satisfaction, which may be manifest in promiscuous striving for affection.

This is a brief summary of the main characteristics to emerge from personality studies of coronary patients.⁽¹⁾ The basic characteristic

(1) Cf. M. Hamilton, Psychosomatics (Chapman and Hall, 1955), p. 90 ff.; and F. Dunbar, Psychosomatic Diagnosis (Hoeber, 1948), p. 293 ff. The most respected, although now dated, textbook on psychosomatic inquiry is E. Weiss and O.S. English (1943), Psychosomatic Medicine (W.B. Saunders, 1957), who present findings of early research into stress factors involved in coronary disease.

is ambitious striving and the wish to be a success, probably masking feelings of inferiority and insecurity, and authority is the focal conflict. From an occupational point of view, the essence of the argument is that this kind of personality is likely to engage in one of a particular range of occupations and that the personality conflicts involved are likely to produce coronary disease; hence the juxtaposition of personality, occupation, and coronary disease.

The emotional stress hypothesis, whether the stress arises out of the individual personality or whether it is associated with family life or whether it is produced by occupational conditions, introduces two crucial and as yet unsolved dilemmas. For one thing, it gives rise to the complex issue of cause-effect relationships. Emotional stress is almost certainly involved. But the question is whether such stresses cause coronary disease or whether coronary disease produces such stresses. Moreover, it introduces the problem of specificity. Even assuming a direct relationship between stress and coronary disease, why should particular forms of stress specifically affect the coronary arteries? Neither of these questions has been resolved.

This brief survey is far from exhaustive, but it does serve to illustrate the complexity of the issues involved and demonstrates the diversity of opinions concerning the causation of coronary heart disease.⁽¹⁾ Beyond broad generalities, no consensus of opinion has been established. Coronary disease has been linked with diverse factors and processes, including heredity, sex, race, age, blood factors, obesity, diet, tobacco, inadequate exercise, occupational conditions, various forms of emotional stress, and personality characteristics, but no single-cause theory has won general acceptance. Indeed, it is feasible that coronary disease may prove to be the consequence of a matrix of

(1) A comprehensive review of recent research is provided by R.U. Marks (1967), op.cit.

factors, in a variety of combinations, involved in a complex process of interaction.

In any event, it is clear that coronary heart disease has a prominent place in the morbidity and mortality experiences of Church of Scotland ministers. There is no immediate explanation for this phenomenon and this could well be a subject for specialized research. It is strange, in view of the fact that clergy of the established Churches are known to be unusually susceptible to coronary disease, to note that the experience of clergymen has not been investigated in any occupational studies of the causes of this disease nor has religion been considered as a variable.⁽¹⁾

(iv) Emotional stress and psychosomatic disorders

It could be concluded from the evidence that emotional stress and intrapersonal conflicts play a significant part in Church of Scotland ministers' experience of health and illness. Signs of emotional stress in the experience of those who have been disabled are unmistakable.

Mention has already been made of the mental, emotional, and personality disorders which have been the third greatest cause of disablement. It has been demonstrated that these difficulties have been increasing in frequency, particularly since 1960 and especially in younger age groups. For example, attention has been drawn to the fact that all of those men who have been disabled under 45 years of age have done so since 1960 and that all but one of these men have suffered from relatively severe psychiatric disorders requiring intensive treatment. Furthermore, depression and anxiety states have been identified in most of these cases. However, it has also been observed that in relation to the total population of Church of Scotland clergy the number of men incapacitated by acute psychiatric disorders is not

(1) R.U. Marks (1967), op.cit.

excessive. But the fact remains that mental, emotional and personality disturbances and difficulties have been involved in at least 11.8 per cent of all cases of disablement.

In addition, however, a surprising number of the cases of disablement have resulted from conditions which many authorities consider are psychosomatic in nature. Psychosomatic is used to denote those disorders to which emotional and personality factors make a significant contribution and in which both psychic and somatic factors are operative in an interdependent relationship. In such illnesses the manifestations are primarily physical, but emotional factors and processes are at least partially involved in the genesis of the symptoms.⁽¹⁾ A simple definition is provided by Hamilton (1955): "Psychosomatic is used as an adjective qualifying an affection in which the personality of the patient and his emotional experiences play a most important part in the development of symptoms".⁽²⁾ He also quotes the definition proposed by Halliday (1943) which describes a psychosomatic affection as "a bodily disorder whose nature can be appreciated only when emotional disturbances (i.e. psychological happenings) are investigated in addition to physical disturbances (i.e. somatic happenings)".⁽³⁾

It is a misconception to consider that psychosomatic inquiry is solely concerned with the presence of emotional and psychological factors in disease. In a sense, it is eclectic and is concerned with the

(1) In recent years some authorities have proposed replacing "psychosomatic" with the descriptive phrase "psychophysiologic disorders" to denote serious disturbances of any organ system caused by prolonged, unresolved emotional conflicts. A Psychiatric Glossary (Basic Books, 1964), p. 64.

(2) M. Hamilton (1955), op.cit., p. 5.

(3) Ibid., p. 7.

operation and interaction of both physiological and psychological processes, with the essential and intimate relationship between mind and body in the person's total experience, and is concerned, more specifically, with the relation between emotions and the physical changes which accompany them. The concept of psychosomatics is based on the assumption that, in some circumstances, "the appearance of lesions in the tissues of the body is related to emotional disturbances".⁽¹⁾

The precise mechanics of such processes have not been established beyond all question, but it is evident that strong emotions such as anger, fear, anxiety, frustration, and elation are accompanied by physiological changes. Whether these changes ever reach a pathological level producing physical disease is one of the fundamental issues raised by psychosomatic theories. It is also necessary to clarify whether the emotional and personality difficulties associated with such disorders are cause or effect. Perhaps, given the unity of the whole person, these and other dilemmas are insoluble. In any event, psychosomatic inquiry has been established as a bona fide field of research which has yielded valuable insights into the nature of health and illness.

While there are abnormal mental states which have no apparent physical or biochemical basis and although it is possible to be mentally healthy while suffering from severe physical defects, it is generally held that some illnesses with physical symptomatology are the outcome of complex causal processes involving emotional and personality factors and processes.

What is relevant in this context is the striking number of diagnoses in these cases of disablement which include disorders often described as being psychosomatic or with which emotional and personality factors have been associated (See Table 43, over). A total of 121 of these 217 cases

(1) M. Hamilton (1955), op.cit., p. 12.

(i.e. 55.7 per cent) have included disorders which are commonly held to be psychosomatic in nature. In 26 of the individual cases two or more psychosomatic conditions have been diagnosed, and in 38 cases various forms of heart disease were also present. In each case the disorder was considered to be chronic and at least partially incapacitating.

TABLE 43: PSYCHOSOMATIC DISORDERS IN DISABLEMENT,
1950-1968

Causes	Total Diagnoses	Associated with other Psychosomatic Conditions	Associated with Heart Diseases
Asthma	6	6	-
Obesity	1	-	1
Diabetes	11	4	6
Parkinsons Disease	5	1	1
Migraine	1	1	-
Amnesia	1	-	-
Coronary Thrombosis	43	10	7
Hypertensive Disease	31	6	14
- (with heart disease)	(14)	-	-
- (without heart disease)	(17)	-	-
Bronchitis/Emphysema	14	6	6
Peptic Ulcers	9	4	1
Dyspepsia	2	1	1
Constipation	1	-	-
Colitis	2	1	-
Arthritis/Rheumatism	10	4	1
Dermatitis	1	1	-
Eczema	1	1	-
TOTAL CASES	121	26	38

It can readily be seen that coronary disease, hypertension, bronchitis, diabetes, arthritis and rheumatism, and peptic ulcers figure most prominently in this list.

The aetiology of a number of these diseases and conditions is in dispute. Extensive research has established a clear association between each of these disorders and psychological factors, even if the nature of the cause-effect relationship has not been conclusively demonstrated. That is not to suggest that innate, biochemical, and physiological factors are insignificant; it is simply to suggest that emotional stress and personality conflicts are among the factors involved. Furthermore, the prevalence of these disorders among disabled ministers would suggest that these individuals have been subject to considerable stresses and conflicts. The effect of these stresses appears to be cumulative, so that they eventually take their toll in physical symptoms and disintegration.

The confusion and controversy concerning the genesis and development of coronary heart disease has been briefly surveyed. But in view of the variety of factors linked with its development, it would appear that coronary disease is properly described as being psychosomatic.⁽¹⁾ While innate and physical factors of undoubted importance, it is generally held that emotional stress and possibly personality characteristics are usually involved in the development of coronary disease. There are many unanswered questions. Whether such stress factors are predisposing or precipitative or directly causal in their operation has not been determined. Nor has the relationship between the stresses experienced by coronary patients and this specific form of physical breakdown been adequately explained. Nevertheless, the fact remains that stress is

(1) Cf. M. Hamilton (1955), *op.cit.*, p. 293 ff; F. Dunbar (1947), *op.cit.*, p. 293 ff; and E. Weiss and O.S. English (1943), *op.cit.*

almost certainly a significant factor in the complex causal process producing coronary heart disease.

Hypertension is another condition which has a prominent place in the mortality and morbidity of Church of Scotland ministers and is commonly regarded as being psychosomatic in nature. Primary hypertension produces such physical symptoms as headaches, fainting and dizzy spells, a feeling of fullness in the head, difficulty in concentration, and fatiguability. It may also have serious secondary effects, causing major damage in organs and systems, and may ultimately lead to heart failure, destruction of the kidneys, cerebral haemorrhage and dementia. Its effects are well known, but its causation is little understood.

Physical factors, such as heredity, a constitutional instability in the vasomotor system, overeating and obesity, are probably involved. However, it is known that many emotions, such as fear, rage, hostility, anxiety and elation, usually cause temporary rises in blood pressure, and some authorities argue that sustained and persistent emotional stress contributes to essential hypertension.⁽¹⁾ When relatively intense forms of stress and conflict, involving strong emotions, are experienced over a long period of time then blood pressure may be maintained at an abnormally high level, eventually developing into a pathological condition. In particular, research has shown the existence of a possible relationship between suppressed or repressed hostility and hypertensive disease.⁽²⁾

(1) Cf. M. Hamilton (1955), *op.cit.*, p. 107 ff. Also R. Dubos and M. Pines (1966), *op.cit.*, p. 148-50.

(2) *Ibid.*, p. 110 ff. A recent Russian experiment with chimpanzees, referred to in an earlier note (q.v. Chapter 2), suggests a close relationship between helpless rage and intense frustration and hypertensive disease. A male chimpanzee was physically, though not visually, separated from his mates and a second male admitted to the females. The first male, having experienced helpless

As in the case of coronary disease, a "hypertensive personality" has been postulated.⁽¹⁾ The hypertensive personality tends to be a submissive, dependent, attention-seeker, showing marked oral dependence on his mother, but also resents and rebels against this passive dependence in ineffectual ways. Repressed hostility is the crucial characteristic. Such patients have developed an obsessive defence system, characterized by over-conscientiousness, a keen sense of devotion to duty, fastidious perfectionism, and sensitivity to criticism. They are neurotically organised, so it is argued, in order to avoid anger, to neutralize guilt feelings arising out of destructive thoughts, and to gain reassurance of their worth.⁽²⁾ Aggression is usually sublimated and expressed indirectly, for example, by excelling in sports, by excessive occupational activity, and in compulsive striving to be a public success. But anxiety is aroused whenever the defence mechanisms prove ineffective and aggression and the consequent guilt feelings break through. Ineffectual or repressed hostility is the emotion most commonly associated with hypertensive disease.

However, this line of reasoning, supported by extensive research, raises the vexed issue of "before and after" states. In view of the difficulties of studying the pre-crisis personality this issue is not readily solved. Is there a personality type which predisposes an individual to be hypertensive or do the neurotic symptoms appear subsequent to the onset of the physical disease? There is no immediate answer. But there is strong evidence to show that emotional stress, particularly associated with repressed hostility, is a major contribution to hypertensive disease.

jealousy and intense hostility, died within three months. Autopsy examination showed that the cause of death was acute hypertension and arteriosclerosis. (R. Dubos & M. Pines, op.cit., p. 149).

(1) Ibid., p. 113.

(2) Ibid., p. 117-8.

Ulcerative conditions affecting the digestive system, most notably peptic ulcers, have also been associated with stress factors and are usually considered to be psychosomatic, if not psychogenic, in nature. Once again, physical factors, such as constitutional biochemical imbalances, excessive smoking, unsuitable or inadequate diet, or careless hygiene standards, are certainly involved. But the emotional factors are not insignificant.

Research has shown that the precipitating events associated with peptic ulcers, and with some allied ulcerative conditions, are "real not imaginary" and are usually related to crises involving security, responsibility, and finance.⁽¹⁾ Problems associated with financial or occupational security are prominent, while sexual problems are prominent by their absence. Personality studies suggest that those who suffer from ulcers are characterized by a facade of independence and aggression which covers a chronic, pervasive feeling of insecurity and inferiority. These deep-seated feelings of insecurity had been established in the frustrating and unstable emotional and economic environments in which these individuals had been reared, leaving a permanent fear of insecurity. These personalities also manifest sexual inhibitions, a tendency to be socially constricted, concern about conventional moral behaviour, and a craving for real superiority and omnipotence which can never be adequately satisfied.⁽²⁾ Personality studies of peptic ulcer sufferers show a great deal of general agreement, with emotional and economic crises prominent, but vary concerning details. However, the stress factor in such conditions

(1) M. Hamilton (1955), *op.cit.*, p. 53 ff.

(2) *Ibid.*, p. 63-4.

is apparently well established and widely acknowledged.⁽¹⁾

Many more examples of psychosomatic disorders could be considered. For instance, asthma is often associated with emotional deprivation and rejecting family relationships, Parkinsons Disease with inadequacy and an attention-seeking need for care and constant attention, chronic constipation with a grim determination to carry on in a 'double-bind' situation although there is no solution, diabetes with feelings of dejection and loneliness and severe voluntary inertia following a personal crisis, arthritis with rigid inflexibility and obsessional perfectionism, and so on. However, these few cases, without further elaboration, suffice to illustrate the fundamental assumptions and problems raised by psychosomatic theories.

Psychosomatic theories and research are concerned with the intimate relationship and interaction between physical, mental, emotional, and environmental factors and processes in the total experience of the whole person. For some reason, this line of inquiry seems to provoke more controversy than almost any other area of medical research. But, given the total unity of the individual person, it should come as no surprise that emotional stresses and personality

- (1) It should be noted that the evidence of therapy has been invoked to refute psychosomatic theories of the causation of peptic ulcers. The condition is effectively treated by bed-rest, reduction of smoking, a strict dietary regimen, and the administration of biogastrone - it has been said that it is the only disease cured by bed-rest. The physical factors involved are not in dispute. But one wonders what could be more secure than a period of enforced bed-rest, with physical relaxation, relative relief from external pressures, and extensive medical and nursing care. Moreover, one wonders whether a "cure" is in fact effected or whether it is simply that the physical symptoms are temporarily alleviated or removed. As is typical of many psychosomatic disorders, ulcerative conditions of the digestive system are usually periodic with irregular remissions and recurrences (cf. M. Hamilton, op.cit., p. 53).

conflicts should or could contribute to the development of physical disease, just as it is commonly held that physical diseases often develop a neurotic superstructure and precipitate personal difficulties. The integrated person is not a 'one-way street' and processes of disintegration are rarely unilateral. Nevertheless, psychosomatic hypotheses and theories do raise considerable problems.

In the first place, the aetiology of psychosomatic disorders is confused in most cases. A variety of factors appear to be operative but the causal links have not been clearly established. It is highly probable that emotional and personality factors do contribute to the development of these disorders, but the question whether they appear as cause or effect, before or after the physical symptoms is a central problem of psychosomatic inquiry. As Balint pointedly asks:

"Which is the primary, a chronic organic illness or a certain kind of personality? Are the two of them independent of each other, interdependent, or is one the cause and the other the effect; and if so, which? Do sour people eventually get peptic ulcers, or does a peptic ulcer make people sour? Are bilious attacks, or even gallstones, produced by the bitterness of some people, or do they become bitter because of their painful attack?"⁽¹⁾

Answers to the cause-effect dilemma seem to depend upon the individual's theoretical orientation and prior assumptions. The question may well be unanswerable and perhaps it is neither possible nor necessary to isolate a primary factor or a consecutive causal sequence. In this context it is sufficient to recognize the presence of significant emotional and intrapersonal conflicts and stresses in the development of these disorders.

(1) M. Balint (1957), op.cit., p. 255.

Another central issue concerns the dilemma of specificity. Even allowing that emotional and personality factors may be involved, what leads to the selection of the specific organ or system in which the malfunction occurs? Interpretations of the relationship between precipitative emotional crises or predisposing personality traits and specific physical illnesses and symptoms usually have strong Freudian overtones and often make liberal use of psychoanalytic mythology and symbolism. Closer examination tends to discount this kind of specificity. It has been demonstrated, for instance, that psychosomatic conditions frequently occur in combination or succession or alternation in individual cases.⁽¹⁾ Moreover, there are remarkable and quite unmistakable similarities between the emotional difficulties and constellation of traits associated with each of these disorders.⁽²⁾ The personality profiles, which are supposedly characteristic of specific disorders, overlap at many points and tend to merge so that absolute distinctions are indiscernible. Compulsive-obsessive traits and conflicts related to aggression, insecurity, and inferiority are common themes. It is more likely, so it is argued, that emotional stress and intrapersonal conflict serve to precipitate physiological malfunctions and symptoms but other factors are present or intervene, such as heredity, constitutional weaknesses and strengths, personal habits and hygiene, which are responsible for determining the specific disease or symptoms manifested in individual cases.

Discussions arising out of psychosomatic inquiry concerning problems of causation, predisposition, precipitation, and specificity are often confused and frequently contradictory. But the implications of

(1) M. Hamilton (1955), *op.cit.*, p. 205

(2) *Ibid.*, p. 206 ff.

psychosomatic investigation cannot be overlooked, especially when considering the health of this group of clergymen. Despite the controversies which this immediately provokes, the very fact that disorders widely regarded as being psychosomatic have contributed to more than half the cases of disablement in the Church of Scotland ministry tends to suggest that these ministers are often the victims of relatively intense emotional strains and personality conflicts. Moreover, in the light of psychosomatic research, it is likely that these stresses and conflicts are commonly associated with difficulties concerning obsessionality, aggression and hostility, inferiority and insecurity.

CONCLUSION

The picture of the health of Church of Scotland ministers which emerges from mortality and morbidity data is generally very positive. By comparison with Scottish males in general and with other professional groups they have been and to some extent still are an unusually healthy group. Only teachers, among the professions, match their favourable record for longevity, low overall death rate, and low rate of death from most major causes. In particular, the evidence demonstrates that they usually enjoy a comparatively high standard of physical health which may be the product of personal habits; hygiene practices, standards of living, and occupational conditions which are conducive to sound physical health. Certainly, those diseases and illnesses which are normally related to harmful habits, careless hygiene practices, or self-neglect are relatively uncommon or completely absent in the experiences of these ministers. There is also some evidence, although it is less reliable and is inconclusive, to suggest

that mental illness is not unusually prevalent in this clergy group. Some ministers, as one would expect, have suffered from acute psychiatric disorders and psychological difficulties; but the numbers affected have not been excessive.

Against this generally favourable background, some negative aspects of their experience have emerged. It soon became apparent, for instance, that Church of Scotland ministers are most vulnerable to coronary heart disease and this is the only respect in which their experience has been notably unfavourable; an experience which they share in common with a number of professional and administrative groups. There is little evidence of a significant increase in the overall incidence of coronary disease among Church of Scotland ministers, but there are indications that it has been affecting men in relatively younger age groups. There is no immediate explanation for this phenomenon, but it seems probable that stress may be a significant factor. Secondly, there are some reasons for concluding that there has been a general, though slight, decline in the overall health of Church of Scotland ministers, particularly since 1960. In the intervening period, their average age of death has steadily decreased, deaths have increased in the 50-64 age group, deaths from coronary disease have increased in younger age groups under 65 years of age, and more younger men have been incapacitated, especially as the result of psychiatric disorders. The magnitude of this decline should not be exaggerated, but nor should the warning signals be ignored. Then, in the third place, there are indications that emotional stresses and intrapersonal conflicts play a significant part in the experience of these ministers. There are grounds, especially when one considers the experience of disabled ministers, for coming to the conclusion that

these ministers are, not infrequently, the victims of stresses and conflicts which eventually take their toll in psychological and, more often, physical disintegration. The sources of such stresses, however, are not immediately apparent. The symptoms are manifest; but to identify and gain insight into the processes from which the symptoms emanate it is necessary to turn to the personal experience of ministers themselves.